Understanding the Constitutive Elements of Negative and Positive Childbirth Experiences in Finnish Birth Care

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Abstract:

Every childbirth is a unique experience for a mother and the whole family. While there is growing evidence that childbirth has long-term implications for a mother's life, and that a personal childbirth experience is in a major role in determining those implications, personal birth experiences have not yet come to the centre of labour care in Finland.

In this qualitative study I investigated the constitutive elements of personal childbirth experiences. The material consisted of 29 birth stories written by 20 mothers, collected as a part of a larger research project Battles over Birth – Finnish Birth Culture in Transition (2020-2023), funded by the Kone Foundation. I divided the stories into positive and negative experiences based on how mothers described the events and their implications. I analysed the role of pain management in all experiences, after which other elements were identified from each story and compared within category and finally between categories. In addition, I analysed the long-term implications of positive and negative experiences for mothers. Systematic content analysis suggested three elements as crucial in determining whether the experience was valued as positive or negative, and these were: 1) pain and pain management, 2) interaction with professionals, and 3) sense of control and self-determination. The birth experience had implications on the mother-infant bond, mental health, trust toward health care professionals, number of subsequent children, general well-being, and confidence in motherhood.

The birth experience thus constitutes of several aspects and can have significant long-term implications. By considering mothers' wishes and treating them respectfully, not only is their constitutional right for self-determination respected, but a safe and comfortable environment can be created for labour. The findings of this study can contribute to developing maternity and childbirth care toward patient-centred care, where personal birth experiences have more value and positive birth experiences can be ensured.

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1. Introduction

Finnish birth care has excellent mortality rates, but there is less understanding of the significance of the mothers' personal experiences. While there is increasing evidence that birth experience has long-term impacts on the mother[1] and that childbirth trauma can cause post-traumatic stress disorder (1-3), more focus on the mothers' narratives is needed to provide a better understanding of what can be done to prevent a traumatic birth experience. The ways in which the mothers' experiences have been assessed have been defective, as the focus of evaluation has been medical interventions in childbirth and how efficiently they reduce pain (4). This approach, however, is insufficient, because every childbirth is different, as every mother brings to the labour her own fears, emotions, past events, and experiences (1,4,5) and a birth experience is much more than the efficacy of pain relief. While there is growing international literature of the relevance of the birth experience, it is still an understudied topic in the medical field in Finland. With the knowledge from this thesis project, I aim to provide evidence and qualitative understanding of the constitutive elements of birth experiences, to move toward more patient-centred care.

Patient-centred care is becoming better understood and more widely used concept in medical care. It can be defined as care that "(a) explores the patients' main reason for the visit, concerns, and need for information; (b) seeks an integrated understanding of the patients' world – that is, their whole person, emotional needs, and life issues; (c) finds common ground on what the problem is and mutually agrees on management; (d) enhances prevention and health promotion; and (e) enhances the continuing relationship between the patient and the doctor" (6). In childbirth, patient-centred care is the key to achieving a childbirth where a woman's autonomy is respected and human rights are respected, thus enabling a better possibility for a positive birth experience (7). By acknowledging and understanding mothers' childbirth experiences and what they consist of, there is more evidence to understand what patient-centred care means and requires.

Salmon and Drew (4) describe the personal, highly subjective birth experience to consist of three dimensions: emotional distress, physical discomfort and fulfilment that

[1] I recognise and respect that not all birth givers identify as a woman or female, but for simplicity of the text I will refer to the birth givers as *women* and *mothers*, with pronouns *she/her*.

relate to a global evaluation after birth. It consists of history: of the mother's own feelings, fears, and past experiences (1,4,5,8). Huopalainen and Satama (9) presented an interesting viewpoint that flesh (the body) and materiality have an entangled relationship in childbirth: the body, machines, clothes, food, and other materials all play a role in the experience of labour. The birth experience has both short and long-term effects on the mother's mental health, the mother-infant bond, number of subsequent children and the child's mental health further in life (8,10-13). A good childbirth experience for mothers constitutes of more than only a healthy baby – an outcome which in a medical setting is enough to determine the labour as "good" (5,14).

As anthropologist Robbie Davis-Floyd describes, we tend to focus on a technocratic way of health care in childbirth, seeing the birthing mother as a mechanical body, while a more humanistic approach could bring the emotional and mental factors into consideration (15). The humanistic model includes the care and consideration of both body and mind and acknowledges the connection between the two (15). Perhaps the ideal way of childbirth care would be a combination of both, since in childbirth, emotions and physical changes are intertwined, yet we have in medical research focused on looking at childbirth through only medical terminology and focus, from etic, observer's point of view, which leads to lack of personal aspects (16). The research has focused on quantitative phenomena and methods, but qualitative understanding is necessary for understanding the *quality* of the experience, as it is this quality that matters in the subsequent life of the mother, the baby, and the whole family (17,18).

In the world of childbirth, a strong polarity is present (7). As the activist Mill Hill said, the polarity extents to several levels, such as women versus the system, midwives versus obstetricians, doulas versus doctors and holistic midwives versus obstetric midwives (7). The holistic model of medicine consists of the idea of the *oneness of body and mind*, the participation of the *spirit*, and the body as an *energy system* that is interlinked with other energy systems (15). Healing is thus not a matter of a single illness or bodily function, but of healing the whole person in the context of whole life (15). This approach is hugely different from the technocratic model of care which is prevailing in most western countries, which is apt to create polarisation between, for example the midwives or physicians who work from the perspective of technocratic care, and the mothers who view the subject holistically. Additionally, different cultures,

world views and religion are factors that can create opposing viewpoints and polarisation between people around the topic of childbirth. These, and all the other levels on which the polarisation is present, do not increase safety in childbirth but rather create tension (7).

Growing discussion and adduction of traumatic childbirths demonstrate that there is a need for improvement in addressing the personal experience in birth care. Campaigns such as #metoo for birthing women ("minämyössynnyttäjänä") (19) have ignited vivid public discussion about women's experiences in childbirth, as numerous mothers have shared their stories from labours that traumatised them, including unpleasant events from mild rudeness to obstetric violence. From social media platforms to news media, the birth experience conversation has spread to other platforms and a variety of stories and experiences have received space in media. For example, a 3-episode documentary *Synnytyskipuja* ("Labour pains") by YLE was released in 2020 (20), and a podcast called *Sydänääniä* ("Heart sounds") (21) discussing childbirth and a variety of birthing experiences started in November 2020. The increased attention toward the topic creates a growing pressure for the medical field to consider the quality of the experience.

Within birth facilities, some efforts have been made to consider the personal birth experience, but so far, they seem to remain insufficient in ensuring a positive birth experience. In postnatal care, discussing and processing the birth experience is routinely only included in the 1-4 day controls (22) and a visual analogue scale (VAS) grade (from 1-10, 0-4 meaning a negative experience) for the labour experience is only asked in the hospital after the birth, where the mother might give a falsely high grade due to the relief of surviving the labour (23). Fear of childbirth became openly recognised in the 21st century (24,25) and today it is an official institutional diagnosis and a part of obstetric literature, which birth experience, in the same extent, is yet not. As a step toward ensuring positive birth experiences, the Helsinki University Hospital (HUS), has formed a working group to ensure patients' rights are fulfilled. Their objective is to consider risk situations and implement practices for documenting whether the birth givers' rights are upheld.

Obstetric violence is not only a national matter – World Health Organisation (WHO) has declared that it is an issue world-wide (26), and the United Nations (UN) issued

global guidelines for labour to reduce the number of unnecessary medical interventions (27) The discussion has been active elsewhere in the world before Finland: in the second half of the 1990s, research from Latin America reported obstetric violence among indigenous and African descendent women, and at the beginning of the 21st century, the extent of the problem in other ethnicities too was demonstrated in various studies (28-32). It has since become evident that this is a global issue and a problem also in Western countries and outside discriminated minorities (33-36).

The term *obstetric violence*, which was first legally defined in Venezuela in 2007 (28,37) has been disputed by some birth professionals and civilians, and the conversation about birth experiences often turns into an unnecessary debate. Health care professionals feel it is unfair to claim that they purposefully hurt women in labour, while the term refers to a form of institutional limitation of women's rights and control in a form maternal care that subjects mothers to the authority of hospitals and rules over their voice and right for self-determination (15,38). In this thesis I will not take part in the debate over the use of the term, as my aim is to provide a study that can narrow the gap between the opposing viewpoints in the birth experience conversation. I will use the term *obstetric violence* when it is used by a source or a mother.

Despite claims that the experienced mistreatment in childbirth is a misunderstanding or a result from an increased number of demands that mothers have (39-41), the evidence of its existence, such as statements from WHO and UN (26,27), leave no choice but to listen to what the message of birth givers is and to confront the fact that Finnish maternity system, despite the low mortality rates, includes problematic aspects that need to be acknowledged. This thesis aims at helping in this task, filling out the lack of understanding of what constitutes positive and negative birth experiences. In addition, the aim is to study the implications of birth experiences, and to provide qualitative understanding for patient-centred care.

In this thesis, I ask:

What are the constitutive elements of positive and negative childbirth experiences?

What long-term and personal implications the childbirth experience had on the mothers?

Which factors and interactional elements should be considered in developing more patient-centred care?

I thus investigate the characteristics of negative and positive childbirth, and features that contribute to the formation of the experience, proceeding from pain and pain management onwards to factors relating to it: interaction between mothers and health care professionals, sense of control and self-determination. Using a narrative approach, I study this from the women's point of view, basing my conceptualisation of negative and positive experiences in an emic viewpoint. With this study I provide insight on the aspects of negative and positive childbirths, and with that information, contribute to the guidance on how to improve maternity care and the childbirth experience of mothers. The thesis now proceeds to present historical aspects of labour, then current practices and on to literature review. Then the materials and methods, analysis and discussion will be presented, concluding with conclusions and suggested implications for practice, limitations, and future research prospects.

2. History

Labour pain is present in most childbirth literature. There is an almost mythical element to labour pain; it is, after all, a pain related to the creation of new life, mentioned is pieces like the Bible. As Laura Kosonen writes in her book *"Suomi synnytti – Kätilöiden kertomaa"* (25), the question of the meaning of labour pain has been asked for decades, as well as whether it is supposed to be felt. As its origin goes back to women's sexuality, an atmosphere of silence and indecency has surrounded it:

> "What you took with pleasure, you must deliver with pleasure." (25)
>
> "Did you scream when this child was made? Don't scream now either." (25)

Labour pain is a historical and cultural question, as the views on what causes labour pain have changed through decades. In the 1960s it was believed that labour pain is a learnt reaction and through diligent practice women can experience a pain-free childbirth (psychoprophylaxis). The role of midwives was to help the mother breathe and stay calm, while the main responsibility was the mother's and she had to "*learn how to give birth*". (25)

In the 1970s, a new generation of birth givers wanted to revolutionise the views on labour pain and demanded medical pain relief (epidural) to be more widely available. A spirited public discussion arose as women shared their views on the topic, demonstrating why the right for pain relief should also be a part of labour. Women shared their views on for example newspapers' opinion sections. (25)

> "In the age of moon landings, heart transplants and so on, women are left to scream in their birthing beds like always. Apparently, this matter isn't important enough. If in this male dominated world men were the ones giving birth, what would the situation be? Would they shout and swear, faces sweating for hours, crippled by pains of the opening phase? I strongly doubt it." (25)

> "When the doctor said goodbye to me, I swore in my mind that I will rather run into the sea than come back here. How this all affected my marital life, is a whole story of its own. I'm just saying that it did. […] It is useless to say that giving birth is a natural event. So is dying, yet the dying people are usually helped to deal with their suffering." (25)

As labour moved to hospitals, there was a strict division of roles: when a mother entered the hospital grounds, the doctors represented medicine, midwives represented care, and the role of the patient was to adapt to the rules. An interesting change of language was noticed by physician Gunnar af Geijerstam from Karolinska Institutet: the credit was given to the physician or the midwife and a mother's role became more passive. Instead of talking about a woman giving birth, it became more common to talk about a baby being delivered[2]. (25) Alongside the hospitalisation of childbirth, the technocratic model for caring rooted deeply to the care of births (15).

The attitudes toward and perceptions of personal birthing experiences have reflected the changing times. Keeping them private or sharing them in confidence, strictly amongst women was the custom for a long time, regardless of whether hospital or home births were more common. The emotions in birth, specifically the difficult and traumatising feelings and experiences were dismissed. Labour was a natural part of women, something that was not appropriate to complain about publicly. *"Be thankful*

[2] In Finnish, 'päästäminen': to let out, and 'synnyttää': give birth to

that you have a healthy child" was often the phrase used to disregard a woman's personal experience of the birth. Though medical improvements have increased the safety of childbirth, the lack for emotional considerations seems to easily remain through decades and a healthy baby is seen to mean a happy and successful labour (25).

> "Almost always this experience [labour] is a positive and happy event, as most children are born full-term and healthy after a well progressed birth." (14)

The measures for a good birth and the success of maternity care have been the mortality rates of mothers and babies at birth, as well as the number of premature and underweight babies (25). In their text about pre-eclampsia in 1998, physicians Rutanen and Ylikorkala referred to ill infants as *problems* and demonstrated their opinion on the importance of improving statistics in perinatal care:

> "Pre-eclampsia is still one of the great challenges of obstetrics and generally the most common reason for maternal mortality. Here [in Finland] it does not cause many maternal deaths, but several children are born underweight and prematurely due to a mother's pre-eclampsia. In these cases, the problem is simply moved from the obstetrician to the paediatrician." (14)
>
> It is clear, that once the aetiology [of pre-eclampsia] is defined, the prevention and treatment of pre-eclampsia and the follow-ups of a pre-eclampsia patient will improve and perinatal statistics in that regard will improve. […] In Finland, the ability to decrease the number of premature births would indeed greatly improve the perinatal statistics." (14)

In the 1970s, the conversation about childbirth and birthing experiences was vivid and the newspapers' opinion sections filled with birthing stories from mothers. Alongside those came detractors who criticised the conversation as *hysteria* and for making childbirth seem like *too big of a deal*. Journalist Pirkko Kolbe wrote about it in Helsingin Sanomat in 1979, wondering why there was such a big fuss around childbirth in public, questioning why women needed special guidance in giving birth and in taking care of a baby. Birthing classes and any type of preparation for labour were criticised: *"people are preparing for labour like for a flight to the moon"*. In the public discussion of birthing experiences in the 1970s, the midwives got their share of criticism. More than midwives, however, the hospital system was criticised, as it put enormous strain on

the midwives by creating hurry and hustle with too few employed midwives. In a women's magazine *Anna* there was a piece written on birth and birthing experiences in 1977 and it said, *"If the midwives had time, they could chat with the mothers, massage, calm them, and wipe. But they usually don't."* (25) This discussion has familiar elements to today's news: many parents feel that no one has time for them at the hospital, and the midwives feel that they do not have enough time for the patients (42,43).

In the beginning of the 1990s, a wave of *active birth* challenged the culture of hospital births and demanded the power in the labour for the mother and that the hospitals need to listen to the wishes of mothers. During the decade, hospitals became more interested in the views of the women and listening to their wishes was stated a part of good care. Writing a birthing plan is a part of preparation for birth today. It is a consideration of fears, hopes, pain management and the role of the midwife, rather than a script that needs to be followed. (25)

> "The birthing experience is a woman's personal view of her own childbirth. It is not dependent on medical facts or on how the health care professionals see it. A problem-free, normal birth is not necessarily at all positive for the mother and on the other hand, a birth full of risks and procedures can be hugely positive in the eyes of the mother." (25)
>
> "Based on research, a positive birthing experience strengthens the mother's confidence and supports the mother-child bond. A negative birth experience, on the other hand, can cast a shadow on the first years with the baby and predispose to for example depression." (25)

Childbirth and maternity are often politically charged topics. For example, in the 1930s, abortion as a topic of discussion developed political nuances instead of its previously medical focus. French predictions presented that the population would cease to grow which raised societal questions across Western countries about what actions would be carried out to prevent the regression of society. In 1930-1940, the focus of demographic policy discussions in Finland was that the key to a successful nation is continuous population growth. (44)

> "The fundamental question of our nation's existence is population growth. All reasons that slow down our nation's healthy growth must therefore be eliminated, as much as possible." President Risto Ryti in 1941 (44)

From time to time, birthing is brought up in the political agenda to ensure population growth demands. Eighty years after Ryti's statement, in 2017, politician Antti Rinne encouraged Finns to participate in *synnytystalkoot*[3] to increase population size. Reproduction and childbirth thus seem to remain fundamental topics in politics and political decision-making.

The politicisation of labour has also been highlighted by analgesia, episiotomy, and personal birth experiences. In 1977, access to analgesia in childbirth was brought to discussion in the Finnish Parliament for the first time (45). As late as 1980s, episiotomy was even more routinely done than today, and it was automatically performed in practically all labours (25). At the turn of the 1990s, the perineum became a symbol of childbirth activism: episiotomy represented institutional power over women and their rights over their own bodies (25). At the same time, studies provided evidence that routine episiotomy is not beneficial, and it should only be performed if necessary (25). In the 21st century, fear of childbirth and childbirth experiences have been in discussion, but as journalist and midwife Laura Kosonen writes (24,25), the centre of all these conversations and changes has been women's fight for their right for self-determination. Perceptions of birth have changed in the course of history, pointing out that even the way of seeing birth today is by no means objective, but also subject to historical and cultural change. What we currently see is precisely the growing cultural pressure to change our perceptions from medically dominated viewpoint towards more patient-centred care that puts birth givers' need in the centre.

3. Childbirth in Finland Today

Between 45 000 to 50 000 children are born in Finland a year (46). Approximately 83% of births are vaginal, and the rest are caesarean sections (46,47). Only about 0.02% of labours are home births (48). 25% of hospital births take place in the Helsinki University Hospital (HUS). Overall, 53% of births are treated in university hospitals, of

[3] *Synnytys* = childbirth, labour; *talkoot* = a form of "neighbourly help that is associated with a strong sense of community" (106)

which HUS accounts for 92%. Only 5.6% of births take place in hospitals without labour wards. 42% of birth givers are primiparous women and thus 58% are multiparous. The largest age group of labouring mothers is 30-34 years. Pain relief is commonly used in labours in Finland, as only approximately 17.2% of mothers do not use any kind of pain relief. 69% of mothers who use pain relief, use medical methods of pain management (47). Approximately 10% of mothers experience a traumatic childbirth, and 1-3% develop post-traumatic stress disorder (PTSD) (23).

In 2018, there were 26 maternity hospitals in Finland (49). Starting from 2016, feedback of these hospitals is collected every two years by the Finnish Institute of Health and Welfare together with the hospitals. Questions vary from the accessibility of the hospital to accessibility of information, the professionalism of the health care professionals to the possibility to be a part of decision making. The results are overall good, for example, 92.5% of mothers were satisfied with the availability of medical pain relief and the mean grade given for the overall experience of the hospital was 4.5/5. However, only 73.6% of mothers experienced that the discussion concerning the events in the labour was useful. (49) In addition, satisfaction toward accessibility of non-medical pain management was only 75.3% (49). This means that every fourth mother feels that they were not offered sufficient care outside the technocratic model, indicating that the maternity care is highly medical, currently serving better those who wish for medical pain relief. The questionnaires were not executed in 2020 due to the COVID-19 situation (50).

Epidural is one of the most used forms of analgesia: in 2019 it was used in 47.8% of deliveries (47). It is administered by guiding a needle into the epidural space after which a catheter is threaded in, through which epidural drugs are administered (51). It can be administered as the labour has started to progress and the cervix to open (52). Other most commonly used medical and non-medical pain management methods are nitrous oxide (“laughing gas”), opiates, paracervical block, pudendal block, and spinal block, and shower, bath, transcutaneous electrical nerve stimulation (TENS) machines, massage, change of positions and acupuncture (52). Nitrous oxide is inhaled through a mask during contractions. It typically contains 40% oxygen and 60% nitrous oxide. Guidance to the use is required to avoid dizziness and nausea (52). In 2019, nitrous oxide was used in 54.6% of deliveries (47).

An episiotomy was performed in 19.3% of labours in between 2007-2019 (53). It is a procedure where an incision is cut on the perineum either along the midline or mediolaterally (54), the latter being the standard in Finland. In 1993, it was performed for as many as 52% of birth givers (55). There is no scientific evidence supporting any unambiguous benefits of a routine episiotomy (56-58). Another routine procedure is cardiotocography (CTG), a way of monitoring the foetus' heart rate. It, too, has no scientific evidence supporting its routine use (59-61). Conversely, the use of CTG upon entry to the hospital increases the risk for following unnecessary operations and procedures, as it is prone to project inaccurate results, causing a false need for interventions (59). The increased number of procedures does not provide a heightened sense of safety for the mothers. On the contrary, many women fear beforehand what procedures they will be subjected to in labour (59).

The great number of interventions seems confusing due to the scientific evidence that most of them are unnecessary. Anthropologist R. Davis-Floyd explains the phenomenon as a part of technocratic health care (15): *"Since the dawn of the Industrial Revolution, western society has sought to dominate and control nature. And the more we controlled nature, including our natural bodies, the more we feared the aspects of nature we could not control"*. The fear the uncontrollable nature has led us to a desperate attempt to control it through medical interventions. As Pallasmaa and Gissler wrote in a Finnish Medical Journal in 2016 (55):

> "It is impossible to determine the optimal number of interventions, but it justified to determine that this optimal limit has been exceeded in the Western countries in induced labours, caesarean sections and ventouse deliveries. Too many interventions increase the risk of complications in labour."

Pain in the first phase of the pregnancy is caused by the foetus pressing against the cervix and the body of uterus close to it. Pain from the contractions causes pain on the lower back and pelvic tissues. Most of the pain in the second phase of labour is felt on the perineum due to its stretching. The knowledge we have on the neurophysiological mechanisms of labour pain is minimal compared to, for example, the knowledge on chronic pain. It is thus mainly based on the anatomical knowledge about the parts and organs involved in childbirth. Fearfulness and feeling unsafe increase the experienced pain, which in turn seems to increase fear and unsafety. Unbearable pain can make

the mother hyperventilate and breath in a shallow way, causing acidosis or alkalosis, as well as hypoxia for both the mother and the baby. (52)

Labour pain is different to chronic pain in also its reason and meaning – for some, labour pain is an important part of childbirth, providing a focus and remainder on the importance of the event and what results from it (62). That pain thus has positive associations and numbing it could even be a negative action. Chronic pain, on the other hand, rarely has any positive associations for anyone. While it is acknowledged that *experiencing intense pain or not receiving proper relief for it can cause mental traumas* for birthing mothers, labour pain is still one of the few types of pain that is not always considered necessary to treat, even if the mother does not associate it as positive (62). To provide the care that the mother needs, it is thus extremely important to understand her own approach and subjective meanings attached to pain.

Current Care Guidelines are "*independent, evidence-based clinical practice guidelines […] The guidelines are intended as a basis for treatment decisions, and can be used by physicians, dentists, healthcare professionals and citizens*". (63). For normal childbirth, there is no current care guideline, only for preterm labours. This may subject the system to a massive variety of different approaches to childbirth care, and perhaps common guidelines built on principles of patient-centred care could unify the care.

In the HUS website, the information available to all describes the process of childbirth as follows (64):

The mother should arrive at the hospital as contractions become intensely painful, and regular less than ten minutes apart, lasting for approximately a minute. As the labour progresses the mother can, together with the midwife discuss wishes regarding pain relief and other factors in the childbirth. Listening to music and finding a good position are ways to relax, prior to the hospital providing pain relief based on the mother's wishes and needs. Cardiotocography, uterine contractions, external examination and bimanual pelvic examination are performed to monitor the mother and baby. The mother is encouraged to find a comfortable position prior to the second stage of labour, with the assistance of the midwife. The new-born, if in good condition, is lifted to skin contact with the mother. The placenta is delivered usually within an hour after the child is born. Injuries are sutured after the delivery of the placenta.

4. Literature Review

4.1. Birth Experience

Compared to physiological aspects of childbirth, the birth experience is still an understudied domain in medical research. In their review article, Simpson and Catling (65) reported that from six scientific databases they found 800 articles with search terms *birth trauma, traumatic childbirth, childbirth, psychological aspects,* and *childbirth post-traumatic stress*. After removing duplicates and articles focusing on physiological trauma, only 47 articles remained.

Identifying pre-existing conditions and predispositions for birth trauma has received attention in research as the understanding of the subjectivity of birth experiences grew (65,66). The fear of an emergency caesarean section, mental health problems and previous negative experience from vaginal birth are commonly identified risk factors (65). In addition, research has focused on mothers' expectations and how those affect emotions in birth: for example, women who expected negative emotions in birth were found to report having experienced more negative emotions, and those expecting high levels of pain were reported experiencing higher levels of pain (67). A shift from this viewpoint of what factors *in mothers* predispose them to a negative experience, to looking at what elements in the childbirth event build the birth experience, has slowly occurred (66).

Childbirth is an event that changes a woman's life in more than only the sense that she enters motherhood: the memories and impacts of the birth experience are now understood to be permanent (18). Interestingly, some presented these sorts of results already 30 years ago: in Washington, the US, 20 mothers who had delivered between 1968 and 1975, were asked to participate in a study regarding their birth experiences (18). 17 out of 20 mothers felt *excited, curious,* or *interested* simply about being asked to participate and talk about their experience. They had detailed memories of specific moments, such as where they were when their membranes ruptured, or focal points in the labour, like how a partner's mouth looked or a hole in a pillowcase. The memory of a childbirth was more re-lived than remembered by the mothers when talking about their experiences. Many of them with a positive experience felt that with giving birth, they had accomplished something great, a goal, or built enhanced self-confidence and self-esteem. Those with negative experience, on the other hand, had accepted a

negative self-image and had become angrier and more assertive in the future. Dysfunctional coping strategies, nightmares and intense negative attitudes toward themselves or others are among other negative impacts of a childbirth trauma (65).

Reisz et al (68) found in their study in the United States that the birth experience affects mothers' confidence in their own maternal abilities. Mothers may see birth as a reflection of their maternal abilities, as childbirth can be interpreted as the first important task as a mother. They found that positive birth experience supported mothers in having higher maternal self-esteem. In addition, they discovered that women who had a positive birth experience used more positive adjectives to describe their baby than those with a negative experience. This was found in association with mode of delivery too, as mothers who delivered by caesarean section used more negative adjectives to describe their babies than those who delivered vaginally. In turn, mothers' perception of their babies and their maternal self-esteem were found to predict caregiving behaviour, which affects the development of relationship with the baby, the mother-infant bond (68,69).

In a Norwegian study about midwives and their role in a positive birth experience, Dahlberg et al (70) found that the most emphasised factors in a positive birth experience were being seen as a decisive factor, and "to be cared for according to their individual needs for emotional support". Thus, being seen as an individual is associated with more often having a positive birth experience. Other factors in midwives' behaviour and role that contributed to a positive experience were trustful relationship, a midwife's presence, and the atmosphere created by those, the midwife's ability to respond to a mother's needs, approach and ability to be compassionate, kind, calm, supportive, competent and skilled. Communication with a midwife and receiving sufficient information from them affected the trust between mothers and midwives. The major role that communication has in the labour is highlighted in the fact that a mother can feel more relaxed and in charge, as receiving information creates predictability. Support, guidance, and coaching created feelings of strength, encouragement, and motivation. This strength, in turn, helped mothers in coping with pain.

4.2. Post-traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) is a severe impact that can result from a birth trauma and has received attention in research of negative birth experiences. In addition to the birth experience, a contributing factor to PTSD is the experience of strong pain, or rather the distress caused by that (71). That is why all who experience intense pain do not develop PTSD. The implications of PTSD are for example lowered ability to feel love and attachment to the child, unwillingness to have more children, a wish to deliver a next child via caesarean section, mental health problems and anxiety (2,10,12,23,72-74). While the prevalence of PTSD following childbirth is low (1-3% in Finland), it is a serious condition with severe impacts and a contributor to fear of childbirth, which in turn has been reported to contribute to the globally increased number of caesarean sections without medical indications (23,75).

4.3. Continuity of Care

In the United Kingdom, Leap et al (76) identified that continuity of care decreased the likelihood of mothers using pharmacological pain relief. Mothers had the same midwives through prenatal visits to childbirth, creating familiarity and the women even described the midwives felt like “friends”, yet the importance of the midwives’ professional guidance and expertise was recognised. The relationship built with the midwives before labour grew the mothers’ self-confidence, as the midwives were felt to be genuinely interested in the mother and child. This built confidence, in turn helped mothers cope with pain in labour.

Reassurance from a familiar midwife increased calmness and reduced panic, decreasing the experienced amount of pain. Knowing who would be there at the time of labour made mothers feel at ease and comfortable. These positive effects before and during labour helped create a positive birth experience and pride after birth. Specifically, mothers felt proud about coping without pharmacological pain relief, which was a result from encouragement and support from familiar midwives. Similar results were discovered in a review that included studies from Australia, England, Finland, Iceland, Indonesia, Iran, and Sweden (77). Knowing the birth professional who was present at labour before the labour was highlighted as a benefit, as it increased confidence that mothers felt.

4.4. Human Rights in Childbirth

The threats to human rights in childbirth are globally recognised. The UN and WHO have addressed the issue and disclosed unnecessary medical interventions and non-dignified and abusive care as issues in current practices that must be eliminated (26,27). The focus of human rights issues in sexual and reproductive care has been focused on a subset of experiences, such as lack of access to emergency care, thus leaving a variety of issues inadequately addressed (78). Stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers and health system conditions and constraints are among those issues (78).

Lokugamage and Pathberiya (7) discuss the aspects of human rights issues in childbirth and the role of evidence-based medicine. While efficient in some areas of medicine, in childbirth it can have a negative impact and diminish women's autonomy, as labours have variations in their progression, need for medical intervention and mothers' wishes (7).

To address an already occurred fault in childbirth care, they suggest a restorative justice process (7). It is "a narrative process whereby the parties to a dispute, conflict or crime are brought into communication in order to find a way to move positively forward and build relationships". It is most used and easy to comprehend in the context of old conflicts (such as post-apartheid South Africa) and court cases, but it has potential to address the concern in health care conflicts too. Restorative justice can range from an apology to "meetings involving stakeholders overseen by a trained moderator". In health care, the aim of the process would include the person at fault acknowledging the responsibility of their actions and the effect of those actions to the individual and the community. In addition, it would mean understanding what produced negative outcomes and hearing and respecting the concerns of the victims. Restorative justice processed have been found to reduce health care costs, positively influence the hospitals imago and patient retention. (7)

4.5. Evaluating Birth Experiences

The most common methods to evaluating birth experiences in research are questionnaires and interviews (66,68,71,76,79). Questionnaires for assessing birth experience can include a combination of, for example, emotion adjectives of which the mothers rate how well each adjective describes their experience, personality trait

questionnaires, or measuring birth expectations with such as Wijma Delivery Expectancy Questionnaire (W-DEQ A) (66). However, the detailed form of the questionnaire can vary hugely depending on the focus of the study. VAS score is used to evaluate the birth experience in hospitals after birth in Finland (23). It is in some sources reported as a non-validated method for evaluating birth experience, while in others it is stated a simple way to evaluate the birth (23,66). It is also used for assessing experienced pain or fear of childbirth (66). The reliability of the VAS score in assessing birth experience is somewhat unclear. Mothers can give too high a score in the hospital after labour, since they can feel relief that they survived it, but not yet understand the true nature of the experience and its effects on well-being, mothering and life in general in the long run (23).

4.6. The Mother-infant Bond

The infant is completely dependent on parents, and the feeling of safety of the child is based on predictability. When important events in life are repeatedly somewhat similar, a child starts to remember these and build associations, such as “mother feeds me, when I am hungry”. As the child grows older, these associations become more abstract, such as “mother is near, when I need her”. These associations can build up if they are consistent and predictable. The feeling of safety that a child experiences from this, is what allows them to spend energy on other things than ensuring safety, such as exploring their surroundings. The early bond and following ability to understand and express emotions creates a model for attachment that a child can universalise to other relationships later in life, as a child and an adult. It has been studied that a secure attachment carries through generations more than others: the “unsecure” attachments (avoidant, anxious and disorganised) presented a fluctuation. For example, avoidant attachment presented by a grandmother turned to anxious in the mother, and again to avoidant attachment in the grandchild. These changes can be a result of intentional plan of a parent to raise their own child differently to how they were raised themselves. (80)

Warm and responsive parenting in early childhood has been found to facilitate a child’s cognitive and social development up to 8 years of age (81). In addition, an insecure attachment to a primary caregiver, such as a mother, has been found to impair a child’s ability to form healthy relationships later in life, and neglect suffered in the early years

of life have been found to increase the risk for depression, anxiety and learning and memory impairments (11). Difficulties in early mother-infant interaction may also cause a mother to perceive a child's temperament as difficult, and some research, while acknowledging the contradictory results across studies, has presented that problems in early mother-infant interaction may contribute to chronic health problems of the child, such as recurrent infections, allergy or asthma (82).

Childbirth experience has been found to impact the mother-infant bonding, with negative birth experiences impairing its natural development (23,68,69). A negative birth experience thus has consequences reaching beyond the mother, to the child and their above mentioned mental and physical well-being and cognitive and social development (11,80,82).

4.7. Home Births

In the United Kingdom, home birth is offered by the National Health Service (NHS), and they suggest mothers choose a place for birth that "feels right to you" in low risk pregnancies – in cases of existing medical conditions and complications, hospital birth is advised (83). In Australia, where home birth became publicly funded by some health services and territories in the early 2010s, a 2013 study (84) reported supportive evidence to home birth being a safe option for women at low obstetric risk. In the Netherlands, women with low risk pregnancies can also choose to either give birth at home or have a short-stay hospital birth (85). For low-risk pregnancies in cases of second or subsequent baby, home birth can be a safe option (86). For women having their first baby, home births increase the risk for the baby and the probability for transferring to an obstetric unit after birth (86).

Home births are in a minority in Finland, as only about few dozen mothers give birth at home annually. Home is chosen as a place to give birth due to it being cosy and an environment where they feel safe, where a sense of control can be maintained, and a continuity of care can be ensured. Women who choose to have a home birth do not tend to make the decision lightly but seek information about it and trust the evidence in the decision making. Negative memories of previous hospital births are a reason behind many home birth decisions. Health care professionals' views on home births can be negative, which may result in mothers not telling professionals about their plans. Plans might also be kept from families and friends. As home births are not

offered by the Finnish health care system, mothers and families need to independently find information about it, including safety and appropriate arrangements. More open, national guidelines could create an environment where mothers are free to make a choice of the place where to give birth, and professionals have knowledge of the risks, benefits, and arrangements for home birth. (87)

5. Data and Methods

The data contains 29 birthing stories from 20 women. The stories were selected from 59 stories from 42 mothers who had sent self-written narratives making sense of birth experiences to *Battles over Birth – Finnish Birth Culture in Transition* (2020-2023): a research initiative from the University of Helsinki (Social and Public Policy), funded by the Kone Foundation. The aims of the social scientific project is to study birth experiences, birth care, the politicisation of birth and the current cultural transition of birth culture, and to provide evidence for developing more patient-centred care.

In the context of this thesis, one birth story means a description of one birth. The mothers could write their texts without strict instructions; thus, they contain what each mother feels is important to tell about each childbirth. Guiding questions (see appendix 1) were provided and to be used if the mother wished to do so. Some mothers strictly answered those questions, while most had written in a free manner and shared detailed descriptions of the entire birthing event and pregnancy, postpartum period and years following the childbirth. All stories were written in Finnish, and I have translated them to English with the highest attempt to ensure the mothers' messages are conveyed correctly. As a reliability procedure (88), the translated passages were constantly compared with the original Finnish texts to ensure there is no shift in the translation: that the word choices are constant across all translations.

Stories to analyse for this study were selected based on pain and pain management. Stories that included no information of those, were excluded first. Second, all caesarean sections were excluded. The numbers of positive and negative stories were not calculated prior to selection of stories or used as selection criteria.

This is a qualitative study, and the material is analysed using content analysis of the birth stories. A qualitative research procedure was selected because the quality of the

birth experience is precisely what matters in the life of a mother, and in Finnish medical research the quality of birth experience is a rather understudied domain. It is important to understand the constituents of negative and positive experiences, and an explorative study is needed to penetrate the topic. While the sample size for a qualitative study like this is smaller than what would be sufficient for a quantitative study, a saturation (88) of constitutive elements of birth experiences is presented in the stories. This means that similar features come up in the narratives and new narratives do not provide new aspect but keep repeating similar topics as the earlier ones. Saturation is considered a criterion for enough qualitative data to depict a topic in a reliable manner (88).

I proceeded to categorise the stories either as positive or negative. Most mothers directly stated how they felt about the birth: *"For me the childbirth was the most amazing experience of my life this far"* or *"the uppermost feeling I had about the labour was disappointment and failure."* The rest also clearly, yet indirectly stated their feelings through descriptions of, for example, unbearable pain or efficient pain management, or long-term negative or positive implications of the labour. In the stories where it is not directly stated whether it was a positive or a negative experience, *all* descriptions of negative and positive feelings and consequences were identified and considered. No story was categorised by only one negative or positive connotation.

Next, I identified all the descriptions of pain and pain management and their effects on the overall experience. The stories were further analysed by identifying other important themes in each story. As *important themes* I categorised themes that influenced the result of the childbirth and thus were given space and weight in the text. *A result* in the context of this study means the mother's experience of the childbirth, not the born child. For example, interaction with health care professionals is an important theme in a story where the mother states that *"the midwives were empathetic and […] therefore, I was heard, and they proved that my feelings and experiences matter"*.

I then compared the stories within the two categories, positive and negative, in regards of the important themes and identified similarities. In addition to pain, three themes were identified as common factors influencing the result of the childbirth: interaction between the mother and health care professionals, sense of control and self-determination.

I emphasise that to develop more patient-centred care, I focus on the mothers' subjective experiences – how they *experienced* the labour as a whole and the events in it. In addition, even though I consider health care professionals as groups (professionals, midwives, nurses, physicians), I acknowledge the variety of personalities, attitudes and working methods in those groups. (88,89)

6. Analysis

The mothers were between 21 and 37 years of age at the time of giving birth, and the stories include births between the years 2009 and 2019. The births took place in 10 hospitals around Finland. Three were university hospitals, three were central hospitals, two were maternity hospitals and two were regional hospitals. The hospitals and units represented were part of Lapland Hospital District, Helsinki and Uusimaa Hospital District, Pirkanmaa Hospital District, South Karelia Hospital District, Päijät-Häme Hospital District, and Hospital District of Southwest Finland. Three mothers gave birth at home.

The variety of the birth experiences goes from empowering to greatly disappointing and traumatising. In the positive experiences, the women felt happiness, safety, relief, and excitement for the future. In the negative experiences, fear, frustration, disappointment, and sadness were prominent. Out of the 29 stories, 15 were from first time mothers (51.7%). In the 18 positive births, 7 were first time mothers (38.9%), while in the 11 negative births, 8 were first time mothers (72.7%).

	Positive	Negative
First-time mother	7	8
Multiparous woman	11	3
Total	18	11

Table 1: The distribution of positive and negative childbirths amongst mothers having their first or a subsequent child

In five births only non-medical pain management was used. Epidural was the most common medical pain relief: it was used in 13 births. In two births, only one type of pain relief was used, and in 7 births, only medical pain relief was used, apart from breathing technique.

EPIDURAL	13
LAUGHING GAS	11
PARACERVICAL BLOCK	8
PUDENDAL BLOCK	3
STRONG ANALGESICS	2
ANALGESIA INJECTION	1
(BREATHING TECHNIQUE)	29
BATH	11
TENS	9
USING ONE'S VOICE	7
MASSAGE	7
SHOWER	6
HEATPAD	3
VIBRATOR	1

Table 2: Pain management methods used in the birth stories. In the blue section are medical, and in the pink section are non-medical methods. Breathing technique was present in all stories, but all mothers did not address it as a pain management method.

For simplicity, from here on I will refer to the mismatch between a mother's wishes and the experienced pain management (availability, efficacy) as *unsuccessful* pain relief, while *successful* pain management will be used to describe the situations where the pain management wishes and needs were met. It does not thus refer to whether the birth giver experienced pain, but to the quality of her experience of the care given for managing pain. What is a successful care of pain is in respect of the mother's own wishes.

In only one of the stories, the overall experience was negative while pain management was successful – in all the others, the pain management was unsuccessful in the negative births and successful in the positive births.

For 17 out of 29 stories, a VAS score was given by the mother. Battles over Birth project asked the narrators to evaluate what VAS score they would give at the time of writing their story, and five mothers gave a different grade at the time of writing their story to the grade they gave at the hospital. The mean of all given VAS grades was, when counting the grades given at the hospital, 7.7. However, when counting with the grades the mothers felt appropriate at the time of writing the birthing story, the mean was 6.6. In the positive stories, for 11 out of 18 stories a VAS grade was given, with a mean of 8.7. In the negative stories, 6 out of 11 were given a VAS grade and the mean

with values given in the hospital was 5.6, and with values given later the mean was 2.5. Especially in traumatic births, the VAS grades indicate that it was asked too early (23): the five mothers state that they only understood the experience and its overall meaning later, and the later-given VAS score is correct. Despite the efforts to develop the evaluation of birth experiences by having public health nurses ask the VAS score later again, based on the stories this did not take place.

When giving the scores at the hospitals after labour, some felt that the attitudes of the health care professionals pressured them to give a good grade, if medically the labour was free from complications and the mother was afterwards congratulated and praised for a successful birth. Sometimes, the well-meaning encouragement of the midwife saying *it went well*, confused the mother's own experience. It is thus extremely important to become more sensitive toward the power relations that take place between mothers and health care professionals caring for the labour. In a vulnerable situation where need of care is present, the boundary of the self and the other is unclear and the perceptions become entangled. This requires extraordinary sensitivity toward the mother's *own* experience.

6.1. Constitutive Elements of Birthing Experience

The main factors that form the basis for the nature of the birthing experience are pain and pain management, interaction between the mother and health care professionals, sense of control and self-determination. These are present in all the birth stories, despite whether the labour was experienced as negative (traumatising or bad) or positive (good or empowering).

6.1.1. Pain and Pain Management

6.1.1.1. Negative Experience

Despite the efficient medical pain management methods, pain management in labour is not always successful, because it is not a matter of only evidence-based practices but a subjective experience, which is not sufficiently cared for in current care. Childbirths where the amount of pain was described as *"unbearable"* were described with terms such as *"long torture"*.

> "The amount of pain was completely unbearable, there was no way I could survive it alive. I started looking at the windows, but I knew that someone

would stop me if I tried to jump. I wanted to escape. I feared I would lose my mind. I forgot I was pregnant." (First child, mother of two)

"It is unbelievable how the amount of pain can keep growing and multiplying even though you think you have already experienced the worst possible pain." (First child, mother of two)

These mothers describe unbearable pain that can cause hyperventilation, which from a medical perspective can lead to temporary hypoxemia of both the mother and child (62). In addition, it can result in the mother losing focus of the situation as she is only able to focus on ways to immediately make the pain end. Similarly to results of a 2019 study in China (13), this kind of severe pain was a contributing factor in childbirth trauma and a factor causing mothers to lose hope during delivery in this study.

"I wanted to die. […] I desired suicide so passionately that it blinded me from everything else." (Second child, mother of three)

The extract above also demonstrates how extreme pain derails the mother's focus away from giving birth and sets her mind on ways to get rid of the pain. Despite many mothers expecting efficient medical pain relief in hospital births, they do not expect a completely pain free labour: in a Finnish study in 1995 (90) it was found that 82% of women wished to first see how the labour and pain progressed, and only when the pain became too intolerable, have analgesia. The results are compatible with this study, as no mother reported expecting completely painless labour in the birth stories.

There can be several reasons for why pain management in a labour is not enough. What works for one person's pain, might not be enough for someone else and it can take time to find the right method of pain management.

"All of a sudden we were in a situation where the pain was colossal due to 6 hours of intravenous oxytocin, the cervix was barely 3cm open after the cervical balloon, and all medical pain relief methods were used and it was not yet possible to get the epidural." (First child, mother of two)

In this situation, the difficulties in finding an efficient pain relief method took time, driving the mother to experience *colossal* pain and distress due to it. The mother demonstrated desperation because the slow progression of labour caused a wait for the administration of epidural and thus a prolonged period of pain.

Sometimes the stage of the labour prevents the use of a specific analgesic.

> "Even though I was promised an epidural as I was moved to the labour room – since I explained I didn't want a same kind of hell of pain as in my previous labour – my new midwife strongly forbid it. She said the labour was not properly in progress as I was only 4 cm open. This started the worst 4 hours of my life." (Second child, mother of three)

Why another type of pain relief was not offered, is not known from this birth story. Feelings of fear and unsafety increase the amount of pain that the birth giver experiences (52), and a situation where pain is unbearable, and the mother does not know when it is possibly relieved, can lead to intensified pain experience and panic, as in the case above. While 98% to 99% of epidural catheters are successfully placed and provide a satisfactory analgesia, some factors result in a failure to reach this success: incorrect siting of the catheter within the epidural space, problematic neuraxial anatomy of the patient and unexpectedly rapid progress of the labour (51).

> "…they couldn't get the epidural catheter in its place. I felt like a pincushion when two anaesthetists took turns poking me, trying to get the catheter in its place without success." (First child, mother of two)

This mother experienced additional pain and distress from the failed attempts to place an epidural catheter. It thus worsened the experience of pain relief not only because it took longer to have the epidural administered, but because she experienced the additional pain from the *poking* of the needle.

There are contradictory suggestions on whether an induced labour is more painful than a natural labour (91,92), and it seems to be a matter of each mother's personal perception of pain.

> "The pain was unbearable. It is said that an induced labour is more painful than a spontaneous labour." (First child, mother of one)

This mother does not disclose if she learnt about induced labour being more painful before or after her own childbirth. However, she explains having experienced difficulties in finding efficient pain relief methods throughout the birth.

Feeling that one has experienced unfair and inefficient treatment and care from caring professionals can lead to loss of trust toward everyone in that profession and in hospitals. Failure to provide efficient pain management during labour, for whatever reason, can be what results in this feeling of mistreatment. In their stories, several mothers also write about insufficient analgesia and local anaesthetic during post-delivery suturing of vaginal or perineal trauma.

> "The quality pain management was everything between lousy and straight-forward bullying." (First child, mother of one)

> "They administered pain relief, but after 30 minutes it wore out, but the midwife was still stitching me up. I told her it hurt me, but she said she didn't have time to administer more pain relief as her shift had already ended. I cried and squirmed of pain as they stitched my genitals back together." (First child, mother of two)

> "The midwife didn't have the patience to administer proper pain relief and the stitching hurt." (First child, mother of two)

In these extracts the mothers describe feeling *bullied* because of how their pain relief was handled. Whatever the circumstances were, it is evident that in the situations where mothers experienced pain during suturing, that should not have been the case and the amount of administered analgesia and local anaesthetics should have been adjusted. In a midwifery textbook (93) the instructions on episiotomy and tear repairs explains that the suturing must be done carefully, as it can easily be extremely painful. They state that to avoid traumatising the mother, the suturing process should be transferred to operating theatre if sufficient pain relief and analgesia cannot be administered. It seems that in practice, however, the current culture of care in Finland enables treatment that does not take birth givers' experiences into account.

6.1.1.2. Positive Experience

Sufficient pain management provided safety and strength for the mother during delivery. A level of pain that is experienced as survivable by the mother prevented panic and helped the woman focus on the childbirth. These effects were found in the positive birth stories, no matter whether the used pain management was medical or non-medical.

> “I felt that I was doing fine with contractions by using the breathing techniques we had practised, and in the morning, I used the TENS-machine.” (Second child, mother of two)

> “The epidural was administered before midnight and it worked very well.” (First child, mother of one)

> “I practiced yoga during the pregnancy and practiced breathing styles. I hoped for as non-medical labour as possible, maybe some laughing gas only. […] As the oxytocin was administered, a horrible pain in my groin area started and it didn’t ease at any point, not even between contractions. I would have been fine with the contractions but couldn’t deal with the sharp pain in my groins and asked for an epidural. This helped enormously until my cervix had opened completely. Then I was given a pudendal block but that did not help. At 9 am I was given the last possible epidural that wore out at 10.30.” (First child, mother of one)

> “I stood in the shower, breathed, moved my hips around, sprayed hot water on my lower stomach with one hand and with the other held the vibrator on my clitoris. I felt that I was safe among people I love in my own home, and I could be myself.” (First child, mother of three)

These mothers had several different kinds of pain management methods in use and they experienced different levels of pain, but they all express satisfaction with how their pain was managed, showing that one method of pain management does not work for everyone and that some individuals wish more medical assistance than others.

A part of successful pain management is in many stories a thorough preparation for labour and knowledge of methods for managing pain. Women who had researched the methods were readier to try various options and find what worked best. This, again, increased their confidence in their ability to give birth and make decisions about their own body and childbirth.

> “I was aware of the different stages of labour and I had looked up pain management methods, both medical and non-medical. […] I felt safe throughout the pregnancy and I was in charge of decisions regarding me” (First child, mother of one)

> “For the rest of the pregnancy I focused on searching for information and practising relaxation and birthing song. I was very happy and trustful.” (Second child, mother of two)
>
> “I also felt intense pain during the delivery, but with different positions, breathing and just giving into it I managed. Knowing that it is all part of the labour had an important role. I felt no fear during the childbirth.” (First child, mother of one)
>
> “I went to the hospital with an open mind; I wanted to try different methods of pain management and at some point, have epidural administered. The midwife suggested stronger pain relief methods as the contractions became more frequents and steadily stronger […]. I was regularly asked how I felt and how frequent the contractions were. […] In the delivery room I used laughing gas, and the midwife and I discussed my wishes about the pain relief methods.” (First child, mother of one)

Here, the mothers of the first three extracts gained feelings of trust and safety through their own efforts to search information and gain knowledge of labour. The reached safety helped them to manage the pain with either medical or non-medical methods. The sensitive care and positive interaction experience that the third mother describes helped her feel safe, as she knew she could trust the help and advice of the midwife. The mothers’ confidence in their own strength was amplified by gaining validation to the decisions they made from the other people present.

6.1.1.3. Key Aspects of Pain and Pain Management

Satisfaction with pain management depends on each mother’s wishes. One rule cannot be applied to everyone, since some want no medical pain relief at all, while others hope to have as little pain as possible and thus all necessary medical help for it. Receiving insufficient pain relief despite requesting it, and unawareness of the reasons why it cannot be administered increase the possibility for a negative birthing experience. Conversely, receiving efficient and wished amount and type of pain management and thus being in charge over those decisions increases the mother’s satisfaction through feelings of safety, trust, and control. The only way to attain successful pain management is patient-centred care, as mothers’ personal relationships with pain vary greatly and thus have different wishes and needs for pain

management. By generalising the administration of pain relief, each mothers' wishes are not heard.

6.1.2. Interaction between Mothers and Health Care Professionals

6.1.2.1. Negative Experience

Interaction, either good or bad, was mentioned in every story analysed for this research and in most it was discussed in detail, emphasising its importance in every patient-professional encounter. The greatest causes for trauma in childbirth were a result of poor interaction between a mother and professionals. In the stories concerning traumatic births, poor interaction contributed to the mothers' fears, confusion, and lack of the sense of control.

> "Well the anaesthetist didn't, at least [have the ability to recognise the mother's needs]. They just snapped at me because I didn't round my back correctly [for epidural]. I already cried of pain at that point. They could have reassured me and try [the placing of the epidural catheter] again or ask my support group to calm me down." (First child, mother of one)

> "When I cried out that I will tear all the way to the rectum if I push, he [the midwife] just said 'that's what's supposed to happen'. I went into shock from this and couldn't say anything. In my mind I was petrified, thinking that I will either die or indeed tear through to the rectum." (First child, mother of three)

> "When it was time to push, the midwife goes somewhere and as she leaves, says 'you can start pushing a little while you're there'. At least she comes back before the baby is born." (First child, mother of two)

> "More than the pain, I panicked because I felt like *no one was supporting me or told me what was happening*." (First child, mother of two)

> "I was in extreme pain and panicking because *I didn't know what was happening and despite trying to reach them several times, the midwife was nowhere to be found and no one talked to us or told us what was happening.* […] Eventually the midwife turned up and *was extremely rude and snapped at me and my partner*. I felt like I was not allowed to exist and that I was in the completely wrong place." (First child, mother of two)

The experienced *disregard toward the mother's fears*, *rudeness, lack of support* or total *lack of communication* and interaction in these extracts caused unnecessary panic, leaving mothers to have to handle that in addition to their pain.

Many mothers needed help and advice regarding, for example, pain management methods and positions during childbirth. Communication that had failed in other areas between the caring professionals and the mother, seemed to fail in this regard too.

> "*Nobody had time to give advice or talk to me.* Instead, we were left all alone to just wait even right before it was time to push." (First child, mother of three)

> "*The midwife didn't give any proper advice or tips for me.* I told her that I need advice with pain management and that I won't take laughing gas or any analgesia that cause nausea, since I vomit easily. The midwife stated that *'well, then the options are shower and later the epidural'*, but I got no other advice." (First child, mother of three)

> "*The midwife offered no advice on how to manage the pain, not even tips on breathing techniques. […] I begged to get any information* about at what point a caesarean section could be an option if the [labour] situation does not progress. *I was given no information or relief.*" (First child, mother of two)

The lack of received advice contradicts with the instructions that some mothers receive in prenatal care; they were advised to not worry about labour beforehand and not prepare for it, as the staff in hospital would take care of everything:

> "I was afraid of labour already during my pregnancy, but the nurse just said, 'Don't worry about the labour and don't plan it. The hospital has experienced professionals who will take care of you and advice you'. Now that I look at it afterwards, *this advice led to me not knowing how to give birth the right way, experiencing obstetric violence and ending up traumatised*." (First child, mother of three)

Some caring professionals feel that the possibilities that mothers have, to search information from the interned prior to labour have negative consequences, such as more demanding wishes and greater disappointments if the plans do not work out (94). In some cases, disappointments do occur as a result:

> "I was disappointed that *none of my wishes and plans worked out, and I no longer trusted myself*. […] I felt that I had been a rubbish birth giver and handled the pain worse than most women." (First child, mother of two)

However, a greater upset resulted from poor preparation and the realisation that the caring professionals present at the labour are not able to help and advice properly:

> "I often felt that *I had more up-to-date information about pregnancy and labour than the nurses had*. I looked up information about possible methods of pain relief and how they might affect the baby. This was not discussed enough anywhere, in my opinion." (First child, mother of one)

> "My first labour, which was very traumatic for me […] I had mentally prepared for the labour *by thinking that they will take care of me in the hospital and with efficient pain relief I will be okay*. I thought that if I go to give birth without any expectations, I will not be disappointed. I didn't want to be a mother who has scripted the entire labour, expecting an orgasmic and empowering experience, and could then end up being disappointed." (First child, mother of two)

All interaction and small talk might not seem important to the staff in the hospitals and perhaps the rush and pressure they are under hinders the level of significance that they see the small moments of interactions having. However, even small things they say to the birthing or new mothers can have a long-lasting impact.

> "I *was shocked by her [a midwife's] behaviour* and what remained with me is when she said, 'put your contraceptives in order *so these kinds of mistakes don't happen in the future*'". (First child, mother of two)

> "I got briefly asked about my birthing experience on the hallway [in the hospital]. I *cried and gave a score 2*. The midwife said, *'well I guess it didn't go too well then'* and that was the end of it." (First child, mother of two)

> "Even though malpractices were carried out during by labour […], *the midwife did not apologise or offer sympathy, not even once*." (First child, mother of two)

> "The doctor encouraged the induction of labour, appealing for example to the upcoming Independence Day, saying that it *would be good to get the labour over with before that* because of staff and their shifts." (First child, mother of two)

Being in a vulnerable situation like childbirth and experiencing cold or unprofessional behaviour was shocking and hurtful for the mothers. The mother in the first extract experienced rude behaviour and unacceptable comment about the child being *a mistake*. In the second and thirds citations, the mothers express their need for a discussion and for sympathy. Lack of these resulted in an experience of negative interaction with the health care professionals. These mothers could have benefited from a restorative justice process (7), where their concerns would have been heard and they would have received even an apology. The mothers above describe experiencing that the professionals in hospitals did not comprehend that this event is special for them, even though for the hospitals, they were just one of many mothers. This is the most clearly portrayed in the last extract, as the mother experienced that she was encouraged to have a medically induced labour simply out of convenience.

Many mothers would have needed an acknowledgement from the health care professionals that something was done wrong or badly in the labour and that there is a true trauma left behind.

> "I tried to talk to them [at the Maternity Clinic during prenatal care] about my severe depression, which I feared would come back due to a stressful situation. That is, they said, a problem that a baby will heal, because *'there is really no time to get depressed, as in a couple of months from now you won't want to talk about anything else than poop'*." (First child, mother of one)

> "To deal with this trauma, I first received no help at all […], or actually, *the trauma wasn't even recognised, because we were healthy, both mother and child.*" (First child, mother of three)

Mothers experienced difficulties in talking about their experiences and having their stories heard. As evident in the first extract above, the mother's narrative is sometimes disregarded even before the labour. After a traumatising birth experience, a restorative justice process could be of help in assuring the mother feels heard and respected and can trust in the health care system and professionals in the future too (7). Disregarding

the issue and experience does not help mothers to disregard it too, but it rather leads to the experience of not being heard, and unsafety as one cannot receive help, even with asking for it.

The different views that mothers and caring professionals have on what is a good labour caused confusion for many mothers. Several labours that were experienced as traumatising by the mothers, were marked as good and normal on paper by the professionals.

> "The main feelings I had about the labour were disappointment and failure. This was extremely contradictory, since *all the midwives and nurses praised how well I gave birth and how well it went.* No one asked how *I thought it went* and they fed me with the idea that it progressed well, while I felt like I had been gang raped." (First child, mother of two)

This confusion about what is a good childbirth created a feeling of disappointment for some mothers, as they felt they had failed in their childbirth, because they felt horrible but the professionals said it was a good labour, and as professionals, they must be correct. Lack of recognition of the trauma resulted in lack of proper postpartum care. Mothers had to survive alone, and it took years for some to get any ease for the feeling of terror caused by the labour.

6.1.2.2. Positive Experience

Positive interactions with professionals and good communication ensured that the woman's wishes were heard and the actions and proceedings during the labour reflected that. Experiencing respect of wishes increased women's trust toward midwives and doctors, helping feel safe during the labour.

> "In the delivery room I got to use the TENS machine and take some laughing gas. […] The TENS and gas helped very much at first. […] I started to feel that I cannot handle the pain of the contractions as the TENS and the laughing gas didn't help enough anymore. The *doctor came to administer a paracervical block. It worked well.*" (First child, mother of one)

> "I was given *more epidural* as the pain started to get unbearable again." (First child, mother of one)

> "The *pain relief was sufficient*, and the *midwives offered different options* for it in time and from those *I chose which I wanted, and they respected me*." (First, second, and third child, Mother of three)

These examples demonstrate how intertwined communication and successful pain management are, and how by listening to mothers' wishes and needs the good result for pain management can be achieved.

Trusting the help present in the labour reassured women that giving birth is survivable. It helped mothers to refocus their attention to the moment and feel confident in their strength. The trust was not dependent on how easy or simple the labour was; in fact, a good relationship with the health care professionals aided mothers through difficult moments and tough deliveries.

Several women with positive birth stories had a doula present. A doula can offer focused support and be a familiar face with also professional knowledge of childbirth, and thus help and encourage mothers in their labour. In the current system for birth care, a mother faces several midwives and public health nurses along the way, which can create feelings of unsafety in the labour, as mothers do not often know the midwife who helps them in childbirth. Many mothers with a previous negative birthing experience chose to hire a doula for their subsequent pregnancy or pregnancies. They found this helpful in ensuring a more positive childbirth experience.

> "She [a doula] successfully *turned my whole view of labour upside down*. I gained confidence for my second labour." (Second child, mother of two)

Positive mother-birth professional interaction gave mothers confidence and strength for the labour and managing with pain.

> "The midwife *calmed me down as she told me what would be done next and reassured me* I could do it. I believed her and I calmed down." (First child, mother of one)

> "The midwife came to introduce himself. We worked very well together straight away. *He calmly explained what was happening now*. The pain of the contractions started to feel unbearable again and *we discussed how we would continue from here on*. […] Inserting the epidural needle and catheter felt uncomfortable as I had contractions at the same time, and it was hard to stay

still. *Due to the great midwife I, however, felt safe the whole time*." (First child, mother of one)

"The childbirth was an unbelievable and unique experience. For that I am thankful for my husband and the absolutely lovely midwife. I felt safe throughout the labour despite the complications along the way." (First child, mother of one)

"Especially *the calm nature of the midwife and repetition of instructions* during pushing made me confident in being able to do it." (First child, mother of one)

"The anaesthetist walks in and on the first try manages to put the epidural catheter in its place. […] The anaesthetist *had also read my information* [about the traumatic previous labour] and I can see pride in their own success on their face. I thank them heavily." (Second child, mother of two)

"Compared to the hospital birth of my first born, the best part this time [in home birth] was my own team and its support; I was encouraged, supported and they believed in my strength. After the delivery I was helped, and my needs were taken care of. I experienced support and love from everyone there. I thank them. The most amazing night of my life." (Second child, mother of two)

The extracts above show how professional, kind, and empathetic behaviour and manner of talking is a small element with a great impact. A good birth does not equal a pain-free or complication-free birth, as described for example in the third and fourth extracts above. Those mothers describe having felt *unbearable* pain and experienced complications, but kind and professional communication from the professionals still ensured a positive birth experience.

As evident in the negative birth stories, rude behaviour can be the only detail one remembers from a person who is treating them. Warmth and kindness in a special situation like childbirth is a small but significant effort.

"The five midwives who helped during the labour were *professional and empathetic*, knew what they were doing, and I had a good feeling about them." (First child, mother of one)

> "The professionals in the delivery room and operating theatre were *unbelievably professional and amazing*, I have nothing bad to say about them." (First child, mother of one)
>
> "A *lovely midwife* tells me she has gone through my information and is determined to give me a very good birthing experience with the other midwife on shift. She *praises* the cooperation of my husband and I, *encourages* us and *says all the right things at the right times*. I trust her completely." (Second child, mother of two)
>
> "[T]he reception [at the hospital] was very *warm and considerate of my wishes.* Not one procedure was executed without my permission." (Second child, mother of two)

Good interaction with midwives or physicians set the tone for the entire experience for these mothers. The kindness that they mention shows that humane communication increases a mother's satisfaction in the treatment and her feeling of safety in the labour. Being *professional, considerate*, *warm,* and *kind* allowed mothers to feel *good, trustful,* and *respected*.

6.1.2.3. Key Aspects of Interaction Between Mothers and Professionals

Small efforts in mother-professional interactions have a large impact on the outcome of the childbirth. Telling the mother what is happening and what procedures need to be carried out requires no extra time but provides safety for the mother. Rude behaviour cannot be justified with any excuse, and it disturbs the possibility for the mother to trust the caring professionals looking after her. In the positive births, good communication that occurred as a result of informing the mother, being kind to her and listening to her wishes, was one of the main factors increasing the woman's level of satisfaction, creating an atmosphere of warmth, respect and listening. Rude, disrespectful communication in turn created a cold, unsafe environment. The significance of the professionals is emphasised in stories where mothers felt unbearable pain or needed to have medical interventions, yet with the kind and respectful treatment from a midwife or physician had a positive birth experience.

6.1.3. Sense of Control and Self-Determination

6.1.3.1. Negative Experience

In the same way as communication, the sense of control and self-determination is mentioned in every birth story and has a major role in most. Lack of them causes fear and panic that can in turn increase the experienced amount of pain and thus lead to a circle of fear, pain and again increased pain (52). Self-determination is tightly intertwined with the sense of control, and the two are thus considered in this chapter together.

Through negative interactions with the professionals and poor communication, mothers lost the feeling that they had any control of the labour or their own body.

> "After the baby was born, a shot of oxytocin was administered before I even noticed. No asking for my consent, no informing me before doing that, nothing." (First child, mother of three)

> "I became aware of the gynaecologist sighing with a big needle in their hand because I was not staying still. They didn't introduce themselves or ask for my consent to touch me. They didn't tell me what they were doing but asked for two midwives to come hold me down and they also asked my husband to do that. I was in complete panic and couldn't speak. The gynaecologist administered paracervical block even though I didn't want it and I tried to fight back." (First child, mother of three)

> "After a moment, I felt the same sharp and stinging pain and realised that the midwife performed an episiotomy without telling me about it and without administering any local anaesthesia first. They didn't administer it even as I was shouting in pain and they knew I was hurting enormously." (First child, mother of two)

These examples of procedures that were carried out without the consent of the mother demonstrate the loss of self-determination. It was taken by carrying out procedures that the mother had forbit, or by doing procedures that the mother had not consented to. The Finnish law on patient's rights states that *"[t]he patient has to be cared in mutual understanding with him/her. If the patient refuses a certain treatment or measure, he/she has to be cared, as far as possible, in other medically acceptable*

way in mutual understanding with him/her" (95). In addition, the Finnish constitution states that *"[e]veryone has the right to life, personal liberty, integrity and security. No one shall be sentenced to death, tortured or otherwise treated in a manner violating human dignity. The personal integrity of the individual shall not be violated, nor shall anyone be deprived of liberty arbitrarily or without a reason prescribed by an Act."* (96) Self-determination, or *personal liberty*, is thus a constitutional right, which cannot be violated in any situation, including childbirth.

The information of what procedures or actions need doing was in some cases shared with the woman, but in a rude way with no regard for the mother's consent. While paying attention to the manner of interaction with a mother might seem maybe insignificant in the rush of the hospitals, it hugely affected the feeling of safety experienced by mothers. As by law, *"[t]he care of the patient has to be arranged so and he/she shall also otherwise be treated so that his/her human dignity is not violated and that his/her conviction and privacy is respected"* (95). The most severe cases of negligence for consent in these stories involved descriptions of physical interference to women's attempts to fight for any control over their own body.

> "An episiotomy was performed to get the baby out easier. As I recall, *my consent was not asked for*, they just said that now we anaesthetise the area, and now we cut." (First child, mother of two)
>
> "Two hours later, after I had been pushing for 40 minutes the midwife said she was performing an episiotomy. *I managed to say no, but she already cut me*." (First child, mother of three)
>
> "The midwife *held my legs while another one held my arms*. Then they started to stich me up. It lasted for over an hour and was done *without any efficient local anaesthesia*. […] This event [is] what I only later learnt to call obstetric violence. They caused me pain, on purpose and forcefully. *I begged for them to stop,* but they *ignored my requests*. They did not give me any intravenous pain relief, even though the cannula was already there, of course. I still cannot understand the meaning for all this. Probably it was protocol, hurry, and inability to understand. But the law was broken in that situation. The law about patient's rights states that the patient must be treated in understanding with them. That was definitely not what happened." (First child, mother of three)

> "I screamed and wrenched as they turned me on my back. *I said several times 'no no no'* and that I don't want to be on my back. Two midwives hang on to my legs spreading them forcefully and holding me down. *I fought against them and shouted no*." (First child, mother of three)
>
> "The obstetrician, a tall and sturdy man, walks into the room. […] He *didn't even greet me* but walked straight to the computer to look at my information. Then he walked to me and said that the labour is not progressing normally, and they will now artificially rupture the membranes and administer oxytocin. *He was extremely rude and bossy*, and I felt like I was subjected to violence. […] I turned my head away and *surrendered*. I felt like I was being raped and the whole room was full of people watching it. I didn't know if the baby was in danger or why they did all this *without giving me any choices*." (First child, mother of two)
>
> "At the hospital *I asked that I could remain standing* while the baby's heart rate was monitored, like I did the last time, but the *midwife would not let me*. That was pure torture of an innocent birth giver: my husband could have held the band in its place around my stomach, but the midwife was not okay with that. I submitted to lay down even though that position made my pains even worse" (First child, mother of two)

These extracts present severe cases causing trauma for women, and they all described these childbirths as traumatising. The mothers were not asked for their consent for procedures, were held forcefully and not provided with enough pain relief where it was necessary. The power relations between mothers and caring professionals in these situations are experienced as fearful and traumatising, when mothers are *cut*, *held*, and *forced* without consent, discussion on explanation. They experienced these situations as *violent*, *oppressive*, and *fearful*, like they had to *surrender* to the treatment of the professionals or *fight* to have any control.

Some mother had received advice in prenatal care to not prepare for the labour but to solely leave everything in the hands of the professionals, and some mothers themselves thought this was the best way to go to labour.

> "I feel that during my first childbirth I ended up in a spiral of procedures and interfering. We went to the hospital too early, I had no means of non-medical

> pain management, the epidural slowed down and complicated the progress of labour […] I didn't know better to question the views of the midwives and I had no wishes of my own, I just agreed to everything they suggested." (Mother of two)

This mother realised during her second pregnancy that her first labour could have gone differently, had she known to look for information beforehand. Lack of preparation combined with poor communication with the caring professionals led to poor outcomes. She experienced lack of control, as *procedures* and *interfering* followed one another and she did not know what pain management methods would work for her, but the methods were selected only based on the midwives' decisions.

6.1.3.2. Positive Experience

Control and self-determination over the choices considering one's own body had a large role in the positive birth stories. This resulted from good communication and, as did successful pain management and positive interactions, increased the feeling of safety for the mothers.

> "I found this a repairing experience. The midwives were empathetic and behaved *as my pain required*, apart from the time when I needed to push. *I was heard*, and they proved that *my feelings matter*. A very different kind of experience than the last time." (Second child, mother of two)

> "Love, peace and trust *radiated from her* [the midwife]. I felt safe and loved." (Third child, mother of three)

Empathy and helpfulness are presented in the descriptions above. The mothers felt *safe* and *significant* because the midwives listened to the mothers' wishes and experiences.

Some mothers who experienced eventful and scary labours felt that a discussion about it after the labour helped them make sense of the events and enabled them to reconstruct a positive birth story despite the initial negative feelings. Procedures that were feared beforehand were experienced as tolerable and manageable due to respectful behaviour from the professionals.

> “The procedure [a ventouse delivery] was explained to me well and I was guided through it. The entire time I felt like I was doing the work and the physician was helping with the vacuum.” (Second child, mother of three)
>
> “In the evening after the labour our midwife came to discuss the labour with us. […] He told us what had happened at each point of the labour and why. The conversation was really good.” (First child, mother of one)
>
> “I asked, why I was moved to lay on my back, against my wishes. The reply was that the baby needed to be delivered faster, so they moved me to a better position for examination. I received praises for my bravery to push against the pain.” (Second child, mother of two)

Even if mothers’ control over decisions was momentarily diminished during these labours, by discussing the events with them, it was reassured that the overall feeling of the labour did not turn negative. In the first extract, the mother describes how she felt an active part of the childbirth because even though the labour needed intervening, the power and responsibility of giving birth to her own child was not taken away from her, but she was *guided* through the ventouse delivery and it was explained to her prior to starting it. For the mothers on second and third extracts, talks with the birth professionals after the birth helped in understanding and internalising the events in the birth. Even for the mother on the third extract, who was moved on her back against her wishes, the conversation was good, because she it was *explained* to her why that was necessary. She was also praised for pushing well, which shows *respect* toward her efforts in the labour. The second and third extracts demonstrate the benefits restorative justice processes can have in childbirth in restoring the mothers’ confidence and trust in health care professionals.

Mothers who chose to give birth at home mentioned self-determination and the control over their own body as significant reasons for home birth, which is compatible with previous studies (87). The positive result of having that control was feeling strong about their bodies and trustful about being able to give birth to the child. They had chosen the people who are present at the birth and were therefore able to trust that their self-determination would be respected throughout the event. Whether the birth happened in the hospital or at home, if a mother experienced these positive feelings, she was able to focus on giving birth to the child, with no need to fear or panic:

> “I trusted my body and my head was able to focus on the pain” (First child, mother of one)

> “The midwife was experienced, calm, professional and respectful. […] My second childbirth was not easy; in fact, in many cases even harder than my previous labour. I had no other medical pain relief than laughing gas, so it took a lot of energy and focus to manage the pain. […] I feel good about this labour though. I feel that I was more present, I felt successful, like I managed and actually, actively gave birth to my child. […] The midwives in the labour were also treating me very respectfully.” (Second child, mother of two)

> “I felt incredibly strong. I had to shout, that’s how strong I was. […] The entire process [the pregnancy and the labour] was extremely empowering. I was an active actor. I was in charge of my own body.” (First child, mother of three)

As women demanded control over the decisions regarding their own childbirth, they were also prepared to carry the responsibility it brings. They researched pain management options, physically and mentally prepared for the birth and the women who gave birth at home carefully ensured they had all the information they need for a safe labour. In hospital births, time was put into communicating birth wishes to the health care professionals.

As some professionals have expressed concern that women in labour have too many demands these days (94) and the reaction to a letter of wishes for childbirth is sometimes defensive, some mothers felt the need to pay special attention to writing a friendly letter that invites for co-operation.

> “I spent quite a lot of time in writing a birthing letter directed at the caring professionals. I tried to form it so that it does not automatically make them defensive but rather invited to cooperation and to helping me, as well as to consider my wishes and my right to decisions regarding me.” (Second child, mother of two)

> “In my birthing wishes I had written […] that I am told beforehand about any procedures that need to be performed and they are discussed with me, and in the case that I am in a state of lowered level of consciousness, with my husband.” (First child, mother of one)

> “Almost every day I did a hypno birth exercise […], read literature [about labour], considered my wishes and fears, chatted with my doula, talked endlessly with my husband about the previous and upcoming births, formed affirmations and mental images, did sports, gymnastics, stretched, rested, talked to my baby, tested my limits in challenges of yoga, gymnastics and mental images, and deeply considered myself and my womanhood.” (Second child, mother of two)

> “My husband and I prepared for the birth by going to a private birth coaching class; I also read literature and went to psychotherapy for 10 times.” (Second child, mother of two)

> “Throughout the entire process [the pregnancy and the labour] it was extremely important to me that all the power regarding decisions about my body was mine. Power includes both responsibility and freedom. I was prepared to carry them both.” (Third child, mother of three, home birth)

The time and effort these mothers put into trying to ensure a positive birth experience demonstrates that women want to be active in their own childbirth and how it has a major significance to the experience. As the mother above mentioned: *“Power includes both responsibility and freedom”*.

Two of the three mothers who gave birth at home were midwives or doulas, therefore they had knowledge about childbirth through their education.

> “I felt safe in my own peace, knowing that no one would interfere with the labour, but I could deliver just as my body knew how to, in my own home.” (First child, mother of one)

Only one home birth was unassisted, as the mother above states, she felt that she could only reach the needed level of privacy by giving birth alone with her husband. Intimacy has a major role in childbirth, and it is extremely important for many mothers. It also increases the vulnerability of the situation, creating a need to acknowledge its significance and provide surroundings and atmosphere where mothers can feel and express intimacy and vulnerability.

6.1.3.3. Key Aspects of Sense of Control and Self-determination

The significance of any patient's right for self-determination is highlighted by the fact that it is stated in the law, and mothers today acknowledge this and demand to have this right. The mothers' experiences demonstrate this importance, and no childbirth where there was no self-determination or sense of control was experienced as positive, and vice versa. Having the mothers involved in the decision making ensured they knew what procedures were necessary and what would ease their pain or help the labour proceed faster. Carrying out episiotomies or other procedures without the mothers' consent and physically holding them down created extreme panic and caused trauma. The childbirth resulted in a positive outcome if the mother was treated humanely, matters were discussed with her and procedures and why they needed to be done were explained and permissions were asked. These were consistent regardless of the place of birth. Mutually agreeing on care and paying attention to a mother's concerns, wishes and fears are part of patient-centred care, which was not practiced in the births that were experienced as negative, but in the positive births these elements were considered and practiced. The mother's autonomy, right for control and self-determination are the cornerstones of patient-centred care and goals to reach, set by the UN (27).

6.2. Personal and Long-term Implications of Childbirth Experience

6.2.1. Negative Experience

In the most severely negative experiences, a mother is left traumatised after childbirth. This can negatively impact the relationship between a mother and child, and the mother's well-being, as well as the infant's (97). Most mothers who described their labour as traumatising, reported difficulties becoming attached to their babies:

> "My relationship with my first-born suffered tremendously because of a traumatic labour. Especially after the birth of my second child, I realised how different everything was with the second-born and how differently I felt towards them. […] I experienced such serious emotional and physical violence in the hospital and during labour that no wonder I have been distant from my first baby." (Mother of two)

> “I wasn’t able to form a bond with my child when they were born, I felt nothing but emptiness as they came to the world.” (First child, mother of three)

> “Yet again, I had trouble becoming attached to the child”. (Second child, mother of three)

There were two exceptions to this, as two mothers, though traumatised, were still able to immediately love and be fond of their babies. All others experienced difficulties.

Depression-like symptoms, anxiety, and despair of life with the baby are among the most serious consequences of childbirth trauma. These symptoms are similar to postpartum depression (PPD), which was not diagnosed with any of the mothers. However, two of the most significant risk factors for PPD are insomnia and stress perception (12); symptoms which some traumatised mothers reported suffering from due to their childbirth experience.

> “For years I tried to forget the feelings of terror, pain, powerlessness, not being heard, loneliness and fear, that were caused by 41.5 hours of labour and the following week [in the hospital]. I tried to tell myself that it is all part of childbirth; that I am supposed to suffer, have nightmares, cry about my experiences, and hate the midwives who treated me. […] I could not connect with my child for the first six months. Until then I felt lost about caring for them, I felt like I was doing everything wrong and I struggled to feel any empathy towards them. […] The baby slept very poorly and I clearly remember how at the worst times I sat, rocking the baby for hours, staring out the window trying to decide if I should throw the baby out from the seventh-floor window, or jump myself. Since I could not decide which of us should die, I didn’t kill either” (First child, mother of three)

> “I had blamed myself for everything that had happened and due to shame I tried to forget the entire labour and not think about it. The more I processed it, the angrier I became. […] I still wonder what I had done to deserve such cruel and heartless treatment, when she [a midwife] seemed to treat other women’s labours relatively well. […] [M]y trauma started to cause symptoms, i.e. I was only able to sleep 1.5 hours a night. […] I feel that I have had no chance of loving my first-born naturally, since they were basically born through rape.” (First child, mother of two)

> "[D]ue to a continuous infection caused by breast feeding I had to be taken to a hospital for intravenous therapy, and a baby who wouldn't eat from a bottle screamed at home. […] for a month I couldn't leave home because I had constant diarrhoea […] I sat at home with a mother from next door […], talking about the feeling that you could throw your baby to the wall." (First child, mother of one)

The mothers in the first and second extracts illustrate not only how serious the impacts of a traumatising labour can be in terms of the mother-infant bond, but how it can leave the woman confused about why they faced bad treatment, and about their right to feel like it was a negative birth experience. All the citations above show the mothers struggling with becoming attached to their babies. Thoughts about hurting themselves or the babies is an extremely serious impact of a traumatising childbirth, and important to recognise.

As mentioned, traumatising labours can cause a variety of negative effects on the mothers' lives. As the mother of the first extract above demonstrates, these negative consequences can last for years and are not forgotten after the childbirth is over.

Traumatising birthing experience can destroy the trust that a mother previously had towards health care professionals. The experiences of mistreatment from even a couple of professionals can cause a universalisation to all hospital and health care professionals, causing avoidance and lack of interest in any communication with them. Lack of trust and even fear can also be directed particularly towards those individuals from whom the mother experienced mistreatment.

> "I get panic attacks in public places when I run into the people who mistreated me in the hospital." (Mother of two)

> "I'm the most afraid of a caesarean section, because then I would be completely in the mercy of the caring professionals, whom I do not trust." (Second child, mother of two)

> "This time, […] I would not trust the hospital caring professionals but hire a doula to support me. From the beginning I knew that I would try to stay away from the hospital for as long as possible." (Second child, mother of two)

The destroyed trust can, in addition to causing the above demonstrated anxiety and unpleasantness, drive the mother to refuse any future treatment either to herself or prenatal care in future pregnancies.

> “I had lost all trust towards midwives, so I refused to meet with them.” (Third child, mother of three)

> “I will give birth to my third child at home, with the help of a hired midwife or even without any help, if needed. I do not see it as an option to give birth in [name of the hospital] for the third time, since I have no trust towards the caring professionals there and I would have to fear to be mistreated again.” (Mother of two)

This avoiding of hospitals and health care professionals can have serious consequences to a mother, a baby or both, as complications and diseases possibly affecting the mother and baby could be identified through proper prenatal care (98).

Negative birthing experience has been found to reduce the number of subsequent children and cause a longer interval to the subsequent baby (10). The fear of a similar negative experience on the next possible labour destroys the will to have more children or prolongs the time after which a mother feels ready or strong enough to face labour again.

> “There is a six-year age difference between my children […], one of the reasons also being the fact that fear stopped me from having another child.” (Mother of two)

> “A year later I supported her (a friend) after a completely inhumane birthing experience. I had already decided that I would not have another child.” (First child, mother of one)

> “For almost a year after the birth of my first child I thought that I might never want to have another child, because the labour was so horrible.” (Second child, mother of two)

Conversely to the mothers above, some women who knew they wanted to have more children, felt that they had to conceive as soon as possible, or they would not have the

courage to do it later, after having had time to think more about their previous, traumatic birthing experience.

> “Suddenly I was in the situation that it could be possible to get pregnant again soon. On one hand I felt that I wanted ‘a rematch’, but on the other, I was scared. I wanted to try my best to make the possible labour go better than the first one. […] My thoughts obsessively focused on pregnancy and I actually got pregnant knowingly and on purpose.” (Second child, mother of two)

> “I thought that if I did not have more children immediately after the previous one, I would not be able to reproduce at all later due to my birthing trauma. Therefore, the new embryo was planted only 7 months after labour.” (Third child, mother of three)

Focusing on the pregnancy and trying to ignore the upcoming labour was a coping mechanism through which these mothers were able to have the courage to conceive again after a traumatic labour. This type of avoidance of thoughts or discussions of the event (labour) is one assessment criteria for PTSD (73).

Childbirth is remarkable in a mother’s life and a unique event for the family (52) and trauma caused by that event left many mothers feeling sad, angry or disappointed, as one of the most special things in their life was turned into one of the worst.

> “I am angry, disappointed and bitter because the most amazing thing in my life had to be birthed like that.” (First child, mother of two)

> “Having a child has been the most wonderful thing in my life, I am just utterly sad about the horrible way they had to be birthed.” (First child, mother of two)

> “Six months after my labour, my friend had a baby. It made me think about my childbirth a lot. I was bitter, because her labour went beautifully, and she was in good shape right after it.” (First child, mother of two)

> “The birth of my first child left me feeling powerless, disappointed, sad and like a failure.” (Mother of two)

> “Once while I was pregnant with my second child, I cried because of the first labour. My husband asked, why I still cry about something that is in the past. I said that I’m crying because of a lost possibility. The birth of my first child

> could have been the happiest experience of my life, but it became an event stained by failure, disappointment, and fear. Nothing can ever replace that, because even if I gave birth again, I could never give birth to my first-born again." (Mother of two)
>
> "I hoped for a calm and empowering birthing experience with as little medical pain relief as possible. It was everything but that. It was humiliating, scary and chaotic. […] Still today I almost start to cry whenever I even think about the labour. I was extremely disappointed with it." (First child, mother of one)

The disappointment and sadness left behind by a negative birthing experience is thus not forgotten after the labour is over. As evident in these extracts and supported by research, it stays with the mother for years, and most never forget it (18). These mothers explain how they knew that a childbirth can be a wonderful experience that sets a great starting point for life with the baby. However, they were left *sad* and *disappointed* because they did not get that good experience. As explained in the fifth extract, while for many women there is a possibility for a *next* childbirth after a traumatising one, that *particular* childbirth is forever tainted with the memory of traumatising events, and each particular birth is important and unique because it marks the birth of a *particular* child.

Traumatising birth experiences negatively impacted the mother-infant bond. In addition, it caused depression-like symptoms and anxiety, suicidal thoughts and even thoughts about hurting the child. It also caused fear and lack of trust toward hospitals and health care professionals, impacted the willingness to have more children and the time between subsequent children. Deep sadness, powerlessness and disappointment were prominent in all stories of negative births. Unsuccessful pain management, negative experiences of mother-birth professional interaction, lost sense of control and self-determination were the elements that built a negative birth experience.

6.2.2. Positive Experience

The births that were generally positive consist of "good" or "empowering" birthing experiences. The birthing experiences in this category were described with terms such as lovely, wonderful, unique, special, kind, natural, free, and full of love.

> “Despite of everything, I felt really good about the labour. It was an amazing and unique experience. […] Actually, I have felt longing for the childbirth. I feel like I was looking forward to it throughout the pregnancy and suddenly it was over, and that makes me sad. I feel like during the labour I did not realise it was actually happening.” (First child, mother of one)

> “The birth of my son was the most amazing and unbelievable experience of my life so far. Therefore, I feel trustful and even excited about my upcoming labour” (First child, mother of one)

The labour was such a lovely experience for these mothers that they mention feeling almost sad about it being over. Time that a mother has for thinking about childbirth during pregnancy is large compared to the time that she spends in labour, thus it might seem that the anticipation of the labour is greater than the amount of time spent giving birth and everything is over in a second. As the mother of the second extract above mentions, it can create a positive anticipation for the possible next childbirth, as the mother can feel joyful to be able to experience labour again.

A good birth was an important *repairing* experience for many mothers whose first or previous labour was negative and traumatising.

> “I felt that this was a repairing experience. The midwives were emphatic and were considerate of my pain apart from the second phase of labour. I was heard and they proved with what they did that my feelings and instincts mattered. Very different experience than my last childbirth.” (Second child, mother of two)

> “I feel that only now [after the second childbirth] I was able to heal from the traumas caused by my first labour.” (Mother of two)

> “A positive birthing experience helped me deal with the previous traumatic labour. I know how to give birth, as long as I am left to do it in peace. […] The first labour was simply awful and terrible, and it cannot be swept away with any excuse of it being my first labour. I am happy and grateful for this experience.” (Second child, mother of two)

These repairing childbirths helped the mothers to ease the emotional pain they had suffered due to their previous traumatic labour, as fear, panic and pain were not the

only things they remembered when thinking about childbirth, but now they also had a *good birthing experience* to carry with them.

All the mothers who gave birth at home described their childbirth experiences as empowering.

> "Throughout the process, having control over the decisions about my body was extremely important for me." (Third child, mother of three)
>
> "The woman herself is the highest authority in her own birthing event." (Mother of three)
>
> "...the best place for us to give birth is home. There my body could have the best possible circumstances to function. I would be safe, surrounded by the people I had chosen" (Second child, mother of two)

These women felt that they had *control* over the events and choices of the labour, which led to them feeling *strong, powerful, proud*, and *successful* after the labour.

Hospital births can also be empowering and have far-reaching positive implications. Mothers reported having a good start to the life with their new child as their mental well-being was good, maybe even better than before due to an amazing, strengthening childbirth.

> "Childbirths have been major strengthening experiences for the relationship of me and my husband. […] The labours have been empowering and wonderful experiences for me, though painful, but the reason for the pain was all worth it." (Mother of three)
>
> "The labour was absolutely amazing, I loved the baby immediately and felt respected, accepted and valuable." (Second child, mother of three)
>
> "This childbirth left me feeling good. I felt more present, successful, and that I really gave birth to my child. […] This childbirth was an empowering experience. […] Now I try to spread positive words and attitudes towards childbirth. […] I also tell people, that it is not just one day, but one day that can have consequences that affect the rest of your life." (Second child, mother of two)

> “I felt in good shape and like I could have done anything. Again, I felt like I could have run a marathon straight away. This time though, there was the emotional well-being together with the physical, and it felt amazing. I was not restless, scared or anxious, but felt strong and calm.” (Second child, mother of two)

> “The labour was an empowering experience and I was thankful that I was able to experience a spontaneous vaginal delivery, since it was what I had hoped for.” (First child, mother of one)

> “The labour as a whole has been the most wonderful and amazing experience of my life so far” (First child, mother of one)

The empowering experience increased their confidence in motherhood, and mothers were able to become attached to their babies immediately, and most described that childbirths were also strengthening for their relationship with their partner. In these empowering childbirth stories, the emotional aspect of birth is emphasised. The mothers felt *positive, wonderful, respected,* and *valuable.* As expressed by the mother in the fourth extract above, physical well-being alone does not provide strength and calmness after the birth, but the emotional well-being was required to reach a positive childbirth experience and the positive impact of it.

A positive experience made mothers feel good about the labour, and strong about themselves. It provided a good starting point to the life with the new child and acted as an efficient buffer for difficulties that may follow in times to come during the first years with the child. A positive childbirth helped mothers who had previously suffered a traumatising experience address their past traumas and know that a childbirth can also be a good experience. In addition, mothers experienced that a positive childbirth had positive impacts on their relationships. The elements that built a positive birth experience were successful pain management, good mother-birth professional interactions, sense of control and self-determination.

7. Discussion

The themes that contribute to the childbirth experience were experienced pain and pain management, interaction between a mother and health care professionals, sense of control and self-determination.

Pain is present in most, if not all conversations regarding childbirth. Efficient pain relief has become widely available and is rightfully expected by mothers who wish to use medical pain management in labour. Overall, Finnish birth givers are generally more satisfied with medical pain relief than non-medical pain management in hospitals (49). For some mothers, experiencing pain as it comes is an important aspect of labour and it has a deeper meaning in the event, thus removing it would remove a significant part of the childbirth (62). Thus, the only way to reach a level of quality in pain management that serves all mothers equally, is to expand the evidence-based medicine to include mothers' narratives about their experiences of pain management, and to listen to each mother at time of labour.

> "The labours have been empowering and wonderful experiences for me, though painful, but the reason for the pain was all worth it." (Mother of three)

The negative emotional implications that extreme pain can have on a person are known and recognised (62) and the mothers narratives support this. Despite this knowledge, some women received advice and comments that indicate that some health care professionals still thought that labour pain does not matter in long-term.

> "The baby was born […], the stitching hurt enormously. I shouted and cried, asking them to take the baby off my arms. The midwife repeatedly said, *'focus on the baby, appreciate the baby'.* I screamed that please take the baby off me before I throw it to the wall." (First child, mother of three)

As some mothers described, the pain was so unbearable it made them desire death. Experiencing this intensity of pain during an event that brings their own child into their lives, understandably negatively influences the mother-child bond. This is not only a personal problem of the mother, but reaches the mother, child, possibly the other members of the family and the society. Children who have experienced neglect, parental inconsistency, and lack of love in the first two years of their lives are prone to suffer from mental health problems and a possibility for overall lower levels of

happiness later in their lives (11). In addition, the early bond is important for the cognitive and social development of a child, and some studies have even shown that problems in the early interaction may subject a child to chronic health problems (81,82). Therefore, a traumatic childbirth and emotionally painful years following it are an issue that reaches more than a mother, reaching to the following generation and possibly causing life-long problems to that child born through a traumatising labour.

Traumatising childbirth experiences are a serious matter also on the level of the national health care system: one person's traumatic event can trigger a chain of suffering that moves from a generation to the next, increasing the needed resources and costs for those. A part of this problem is the different view of mothers and health care professionals on what is a good labour. Traumas go unrecognised when only the physical aspects of childbirth are regarded when determining the success of the childbirth. As no trauma was recognised, several mothers had to survive with emotional and mental health problems for years, and some still did at the time of writing their story.

In the most severe cases of traumatising childbirth experiences the mothers described some of the treatment that they received with terms like *obstetric violence, rape,* and *bullying.* They experienced unsuccessful pain management and lack of control as their wishes were not heard and they were subjected to procedures without their consent. Several mothers felt that they were not treated as humans in the hospital, but as *objects, pieces of meat* and as patients incapable of making any decisions over their lives. This can be particularly harmful in a situation like childbirth: it is an event where a mother's emotional state has an important role, and that emotional state impacts the rest of the mother's life, as well as potentially the child's development. Childbirth, however, is not treated with these facts in mind in Finland. We tend to forget to add aspects of humanistic model of care to the rooted technocratic model (15).

> "Technocratic physicians do not value lengthy conversations with their patients, preferring to keep their visits short. Although it is well-known that touch and caring are powerful factors that can positively influence both a woman's experience of labor and the outcome of the birth, it is rare to see obstetricians touching laboring women, holding their hands, or sheltering them in an embrace." (15)

Women's emotions should be cared for in labour, because emotions affect the progress of the labour, since the emotional state and physical changes are intertwined (16). In addition to the emotional aspects that disrespectful treatment in childbirth can affect, it is a matter of every patient's right for self-determination. It is a constitutional right of every person and a lawful right of every patient (95,96). In that sense, childbirth is no different from any other patient situation: whether one is at the dentist or in labour, the same rights apply, and the right to decide over care and procedures applies, as does the right to receive respectful, humane care.

The problems that hospitals as institutions have are widely recognised. The most prominent issue is probably the hurry that midwives are in, as in most hospitals there is not enough staff, as experienced by both patients and professionals (99-101). Several mothers also brought this up in their stories. Many mothers also reported that the midwife caring for them changed from one to another in the middle of the pushing stage of the labour, which caused disturbance, loss of focus and, if the next midwife was rude, fear and anxiety. The total number of midwives, nurses, and physicians that one mother had to face and be treated by during pregnancy and labour was also mentioned to be disturbing and uncomfortable. The company of a familiar person increased the sense of safety, and this lacked for many mothers who had a negative experience. It is possible that a mother's nurse or midwife changes countless of times from the first check-up to the last postpartum visits.

In our current health care system, it is difficult to ensure that the same professional(s) could treat one mother throughout the pregnancy. However, if changed, it could greatly improve many mothers' pregnancy and birth experience, based on the findings of this study and other research: continuity in the prenatal and labour care has been found to increase mothers' calmness, self-confidence, and ability to manage pain (76). Many mothers have independently searched to patch the discontinuity by hiring a private doula, which is not funded by our health care system and therefore all mothers cannot afford it. The role of a support person, such as the mother's partner, is great for the same reasons: to have someone familiar offer support along the way. The partner, however, is not a person who usually has professional knowledge and advice of labour to offer, which is what many mothers said they needed. If the midwife who cared for the woman during labour happened to be someone they had met before, it was considered a huge benefit.

"The midwife was a familiar face, […] I felt trustful." (First child, mother of one)

The current amount of information and quality of prenatal classes offered by the public health care system seemed insufficient for some mothers, as they stated that they, for example, had more up-to-date information of pain management methods than the public health nurses at prenatal visits. This study, while based on a limited size of data, suggest that first time mothers are more vulnerable to experience a negative childbirth (72.7%) than multiparous women (38.9%). It is worthwhile to consider whether more comprehensive prenatal classes would better serve first time mothers in preparing for labour and knowing their strengths, wishes and rights.

Mothers wished for respectful interactions and consideration that they can make decisions, and when this occurred, it increased the satisfaction toward the treatment and the birthing experience. R. Davis-Floyd discussed these same issues: communicating with the patients kindly and respectfully, looking at them as individuals who have both a mind and a body has a strong potential to improve the western way of medicine (15).

A part of respectful behaviour toward mothers is acknowledging when they were not treated well and admitting it. Mothers who experienced a traumatising childbirth disclosed in their stories that they would have needed an apology or a discussion about what went wrong in the labour from the health care professionals. As this did not happen, the trauma stayed with them and they felt left alone. Mothers who in their labours had some negative aspects, but afterwards had a respectful conversation with the professionals who cared for them, and received answers for why, for example, all their wishes were not respected, found this beneficial and it helped in prevention of trauma. This kind of restorative justice process is not only beneficial for mothers, but on a societal and institutional level too, since a negative childbirth experience can lead to fear and lack of trust toward health care professionals and the health care system. This fear led some mothers to avoid monitoring appointments during a subsequent pregnancy, or even rather want an unassisted home birth than another hospital labour. Avoidance of important health care check-ups can lead to undiscovered diseases and complications (98).

Improving childbirth experiences is a global human right's issue. WHO declared obstetric violence a global issue and UN released guidelines that advice to decrease

the number of unnecessary medical interventions in childbirth (26,27). They state that every mother deserves to experience a safe and good labour. In addition, respectful and dignified care both in labour and before it must be initiated and emphasised. In the negative birth experiences, these are not fulfilled, as women are treated without the patient – the mother – being the centre of care and the highest authority in decision making. As a member of the UN, we are as a state committed to follow these guidelines. This, of course, should not be the primary reason for improving our maternity care, but it is an aspect to consider. Besides, if birth experiences in our public sector health care system were to deteriorate, it could lead us to a situation where additional, hired support from private sector is needed more and more by mothers in order to have a positive birth experience in hospitals, resulting in an unfair setting where only those who could afford to hire help from private sector can experience a positive childbirth.

Finland has become aware of the human rights issues of childbirth perhaps later than many other countries. In the United Kingdom, for example, an organisation called *birthrights* (102) was founded already in 2013 to improve women's pregnancy and childbirth experiences by promoting respect of human rights. Recently, there has been more movement toward demands on human rights and autonomy in childbirth in Finland too. The issue has been taken more seriously by authorities, institutions, and professionals, as for example the beforementioned work group in HUS has been founded. In addition, there is now an association called *Synnyttäjän oikeudet ry* ("the birth giver's rights") in the planning.

The timepoint for the VAS score is worth to consider. Five mothers changed their VAS score weeks after labour, which demonstrates the long-term impact on the mothers' emotional aspects and how it can take time to comprehend the experience. In addition to the current practice of going through the birth with a mother after labour, a second check-up could be beneficial as a common practice, and a more reliable VAS score could be asked at that time. If it is not recognised that it can take time for a mother to recognise her trauma, she might be left to handle the underlaying trauma on her own.

Improving the defects in our childbirth care is important in ensuring that mothers do not need to suffer from trauma or even PTSD because of a birth experience, that they

can trust our health care system in the future too, and love and care for their children straight from the start.

> "In my experience the significance of childbirth does not come down to the pain and effort of that one day. In my case it has resulted in deep changes in many areas of life, and not just because the result of childbirth is a new person that revolutionises the lives of the parents. The childbirth itself, as an event, matters even though this is often not recognised and acknowledged." (Mother of two)

The themes that affect the childbirth experience: pain management, mother-professional interaction, sense of control and self-determination, are not impossible to take into consideration, but can be paid attention to and respected with even small changes in practices. Afterall, these are a part of humane and respectful interaction with patients, which is not only a matter of the law and human rights, but of good practice. The significance of human interaction in labour is highlighted in cases where mothers had fears, or experienced unbearable pain during birth, but still had a positive birth experience. They all mentioned the role that a kind midwife, physician, or doula, either at home or in the hospital, had in ensuring a positive experience despite some negative aspects. This demonstrates how, for example, efficient medical pain relief is not the most important aspect of childbirth but how respect, kindness and support can create a sense of safety and carry a mother through the sometimes-tough experience.

The findings of this study are in line with previous international research. Similar constitutive elements, pain management, nature of interactions with birth professionals and sense of control and self-determination, have been identified by mothers in other studies (70,72). When the mothers' wishes regarding pain management were heard and respected, professionals acted professionally and kindly, and mothers had a sense of control and self-determination, *dignified, respectful, patient-centred care* extended to all the constitutive elements of the birth experience and a positive birth experience was reached. In negative birth experiences, where pain management was unsuccessful, interaction with professionals was poor and mothers' lacked a sense of control and self-determination, *the lack of* dignified, respectful, patient-centred care was evident.

The long-term implications were in line with previous research as well. Mental health problems, impact on the mother-infant bond, number of subsequent children or age difference between them and confidence in motherhood have been recognised in other studies too (1,18,23,69,71,72,79,97,103). Interestingly, lack of trust toward health care professionals was mentioned and discussed by several mothers in this study but has not been recognised in other studies as strongly as the other long-term impacts mentioned above.

8. Conclusions and Implications for Practice

Themes that build a positive or negative childbirth experience are pain management, interaction between a mother and health care professionals, sense of control and self-determination. Through these, emotions such as safety, calmness and trust could be established. All these themes are linked to each other, as successful pain management was achieved through good communication and interaction, and those, in turn, provided a sense of control and self-determination.

Implications of a negative childbirth experience were lack of trust in health care professionals, inability to form the mother-infant bond, lowered number of subsequent children, anxiety, depression-like symptoms, and consequently, negative effects on relationships. From positive childbirths, mothers gained self-confidence as women and mothers, became fond of their children immediately, and overall felt both emotionally and physically well.

To ensure positive childbirth experiences, the focus must be on treating mothers in labour as humans rather than patients. Humane interaction, such as asking for the mother's wishes, plans and consent for procedures has a huge impact on increasing the sense of control and self-determination of the woman. Kind, respectful behaviour, such as introducing oneself when meeting a new mother, and explaining what could or must be done next does not take extra time but includes a mother in the decision and ensures that she is treated with respect. Considering her wishes in regards of pain management increases the sense of safety, which in turn creates calmness and a sense of trust, allowing the labour to proceed naturally. Noting that everyone views, and experiences pain differently is as important as having efficient pain management

methods available, since ‘one size fits all’ way of looking at the matter inhibits us from noticing the personal wishes of each mother.

On a more national and institutional level, changes in the structure of maternal care would have positive impacts on the childbirth experiences. Mothers expressed that the discontinuity of care from pregnancy to birth is disadvantageous and disturbs the formation of trust toward the professionals at labour and feeling safe in the hospital. Having fewer changes in health care professionals who care for one mother would provide a familiar face at the time of vulnerability. In addition, it seems that in an especially vulnerable position to suffer a negative birth experience are first time mothers who did not know to prepare or were not helped to prepare properly. This must be kept in mind, as it can indicate that the preparation services available are insufficient. Similar flaw is suggested by a Finnish study which found that first-time mothers who received more preparation (a leaflet and a two-hour class where families could familiarise themselves with different types of labour pain management methods, push positions and delivery instruments) than what is funded by public health care, experienced less fear of childbirth (104). A system where a mother meets with her midwives before labour and is given more thorough preparation guidance would better serve mothers. We also need to critically evaluate the way we do routine procedures and interventions in hospitals, as most of them have no scientific evidence supporting their routine performing.

To better prepare health care professionals to meet mothers who have previously experienced a traumatic childbirth, they could be offered training on trauma-informed care (105). It could equip them to better understand the sensitivities present in caring for a mother with a previous traumatic childbirth, and in turn help mothers in re-gaining the possibly lost confidence in health care professionals and ensure a traumatic childbirth does not occur that time.

To move toward more patient-centred care, it is important to take into practice the focal points of patient-centred care that apply to childbirth: consider the patient’s concerns and need for information, understand the patient as a person and their emotional needs, mutually agree on methods of care, promote both mental and physical health in the future, and enhance the continuing relationship between the patient and the caring professional or institution (6). We can see that the findings of this study: the

constitutive elements and implications of birth experiences, strongly link to the cornerstones of patient-centred care. Thus, by moving toward patient-centred care in childbirth, the important elements of birth experiences are concurrently taken better into account. Mutually, by understanding and considering the elements of birth experiences in care practices, the practices become more patient-centred.

9. Reliability and Limitations

The sample size for this study is 29. Thus the results of this analysis cannot be empirically generalised, but they give insight to the key factors and the mechanism of successful and failed pain management and positive and negative childbirth experience, hence via studying the quality of experiences and relationships we gain nuanced understanding of the aspects of birth care that need to be focused on. The *particularity* rather than *generalisability* is the strength and hallmark of qualitative research and the qualitative results can be generalised into a broader theory together with results from other studies (88).

The identified themes of this study conform to those presented in other studies related to similar topics. This adds to the validity of the findings of this study (88).

My educational background is in life sciences and medicine, which brings to this study the bias that I have had more experience in analysing quantitative results and research and in looking at medicine-related phenomena from a quantitative, emic point of view. However, to reduce this bias and add to validity, I have spent time discussing with and learning from other researches in the field in a multidisciplinary Birth Research Network, who all work on varying topics around the research project Battles over Birth.

This study does not disclose the viewpoint of the physicians, midwives and nurses that were present at the described events, because the birth experience and its implications result from particularly the mother's subjective experience, and the professionals' views do not add depth to the findings. However, it is important to understand the viewpoints of health care professionals to understand possible limiting factors for positive interaction and childbirth care. Additionally, it is important to understand how birth professionals' occupational well-being is, and what they need to

provide humane, quality care. These aspect from birth professionals' point of view could be a prospect for further research.

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Appendices

Appendix 1: Guiding questions for birth stories

We are interested, for example, in:

- Personal experiences, different birthing methods and places and the significance of childbirth
- Personal wishes and needs and how those have been met
- Experiences during pregnancy, treatment of pregnancy and special care (due to i.e. risk pregnancies or fear of childbirth
- Emotions toward labour and its treatment, such as joy, empowerment, powerlessness, fear, anger, disappointment, shame
- The experience of pain, pain management methods used and how efficient those were
- The health care system and different health care professionals, and their way of acting and ability to identify a birth giver's needs
- The experiences of "different" birth givers or birth giver part of any minorities
- The presence, way of acting, help or lack of them from a partner or other supporter in the childbirth (e.g. friend, family member, doula)
- Interaction with maternity care and health care professionals in the hospital
- Social expectations, attitudes of close persons or outsiders
- Implications of the childbirth (e.g. injuries or traumas), recovery time and postpartum period
- The addressing of the childbirth experience and support given for it, or the lack of it
- The effects of the childbirth experience on motherhood and family life